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THE CRISIS IN HOME HEALTH CARE: GREATER NEED, LESS CARE

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

NINETY-NINTH CONGRESS

SECOND SESSION

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THE CRISIS IN HOME HEALTH CARE: GREATER NEED, LESS CARE

MONDAY, JULY 28, 1986

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Philadelphia, PA.

The committee met, pursuant to notice, at Senior Citizen Center, 509 South Broad Street, Philadelphia, PA, Hon. John Heinz, chairman of the committee, presiding.

Present: Senator Heinz.

Also present: Stephen R. McConnell, staff director; Lucia DiVenere, professional staff; Isabelle Claxton, communications director; Mark Parcells, professional staff; Kimberly Kasberg, hearing clerk; and Gretchen Meinke, health care fellow.

OPENING STATEMENT BY SENATOR JOHN HEINZ, CHAIRMAN

Chairman HEINZ. Ladies and gentlemen, good morning.

This hearing of the U.S. Senate Special Committee on Aging is to receive testimony on an issue that deeply concerns all of us; namely, the reports of inappropriate, even illegal, denials of critical home health care to thousands of sick, older Americans.

In 1984, home health coverage under the Medicare Program accounted for only $1.9 billion. That seems like a lot of money, but it is only 3 percent of total program expenditures in 1984.

The service provided to the home-bound Medicare patient include: skilled nursing care; and physical, occupational and speech therapy.

As the committee learned in hearings last fall in Washington, DC, Medicare's new reimbursement system for hospitals, prospective payment, has fueled a rapid increase in need for the home health care benefit.

Prospective payment sends patients home from hospitals sicker and quicker, more often in need of high levels of followup care. But instead of the starched cap and healing services of a visiting nurse, a growing number of these Medicare patients get only an envelope with a notice of benefits denied.

The demand for home health, as measured by the number of hospital discharges, has increased 37 percent since October 1983, when Medicare prospective payment began. Yet, for this same period, data from the Health Care Financing Administration shows a 133-percent increase in the benefit denial rate, with more than 2½ times as many claims denied in 1985 as when the prospective payment system began.

Nothing could be more appropriate in these budget-bound times than to sweep Federal programs clean of all fraud, waste and abuse. But when it comes to housekeeping in home health care, the administration has gone too far.

We will see a video today of four seriously ill Medicare patients in Pennsylvania who have been denied care that is rightfully theirs under the law.

We will hear testimony confirming seemingly capricious interpretations of the Medicare law by the Health Care Financing Administration and the fiscal intermediaries.

We will learn how a 1984 mandate from the Health Care Financing Administration stripped frail beneficiaries of their ability to appeal benefit denials.

And we will hear how a growing number of home health agencies are turning away patients rather than absorb the risk of financial loss from denials.

Too often, the administration's rationale for these denials reminds me of the massive cut in Social Security benefits to mentally disabled Americans a few years ago. Then, individuals with lifetime histories of mental illness were declared well because they could walk a dog or play a piano or visit relatives, even though they were still so mentally disabled or hurt that they could not, in any way, hold a paying job.

Today, a 70-year-old cancer victim, living alone in a room in a boarding house, who needs oxygen to breathe and weekly blood work to fight his cancer, was denied his needed home health benefits because he walks down 10 steps to eat in the restaurant beneath his room. According to the fiscal intermediary, if he could walk to the restaurant, he did not need home health care.

A report prepared by the Senate Special Committee on Aging, to be released this morning, contains seven recommendations for change.

The underlying principle behind all of these proposals is really clarification; clarification of technical terms such as homebound and intermittent; clarification of benefits due. We need to establish once and for all that a clear road to care exists for the 1.4 million older Americans who so desperately need home health care.

In 1985 here in Pennsylvania there were approximately 135,000 Medicare beneficiaries who sought home health care. That's about a 50-percent increase over 1980, when there were some 91,000 beneficiaries who needed that kind of care. And yet, to put a point on the seriousness of the problem for Pennsylvanians, during an 8-month period ending this March, with only 75 of approximately 300 home health care agencies reporting, more than 2,300 Pennsylvanians were, at least in my judgment, unfairly and wrongly denied their Medicare home health benefits.

So, it is a problem that strikes here in Pennsylvania quite directly and severely.

I would like to welcome our witnesses this morning. I know you were ready for this hearing once already and I'm glad you were patient with us for 1 more week while we rescheduled.

To the 135,000 Medicare beneficiaries who receive home health care in Pennsylvania, this is a subject of some vital importance. I think that it is very important for us to examine these issues and

develop a better understanding of the problems and the solutions needed to assure that high quality health care is available to those in need.

Our first witnesses this morning are joining us by videotape. They are four Medicare beneficiaries whose stories we will hear in a minute.

Each of them, though, has one thing in common: They have been denied Medicare benefits for needed home health care services.

Some are unable to be with us because they are just too frail—they could not travel without serious risk to their health; others because they are literally homebound—they are unable to leave their homes without great effort. Their cases are described in greater detail in the material that was made available outside.

Each of these cases, I believe, demonstrate the need that Medicare beneficiaries and their families face for home health care.

The first witness we will see is Mrs. Florence Bodie. Mrs. Bodie is 92 years old and lives with her daughter, Charlotte Taylor, in Wilkes-Barre. Mrs. Taylor is with her mother in the tape. Mrs. Bodie is bedbound and needed home health care for complications that set in after a toe was amputated.

Mrs. Florence Bodie.

STATEMENT OF FLORENCE BODIE AND CHARLOTTE TAYLOR, WILKES-BARRE, PA

Mrs. TAYLOR. Momma has been home with us for 7 years. And she was pretty good until then in Mobile. But about 2½ years ago she had a slight stroke, and that makes her right arm not usable.

She has been in bed and upstairs for most of the time since then. We have not been able to get her downstairs.

Then last October, one morning I went to wash her, she drew her foot away from me. I didn't realize what it was, and I thought, oh, I can cure this. I thought it was a toenail and soaked it in hot water.

But that night I called the doctor. When I started to undress her for bed, I noticed that the toe—the color had not gone down. It was bright red. So the doctor came that night, and the next morning he took her to the hospital. And she was in the hospital, altogether, 21 days I think. And on November 6, they removed the toe. And she came home here the 18th of November.

The first day I had her home, that toe started to bleed. And I really was scared. I asked the doctor if we could have help then, because I was afraid to get her out of bed or anything, then, because of her foot. And so we had the home health nurse, Sandy Yates.

And they dressed the foot for me. And then the aides took care of her bath.

The nurse would come. And you would feel relieved, because she took all of my mother's vital signs, which I cannot—I do not know how. You know, they had blood pressure and everything like that. And they always dressed the foot.

We used to bathe it and put peroxide on it and soak it. And we had to cut part of the scabs off to make it better. And they gave me pointers on—because I am not a nurse or anything like it—they gave me pointers on how to care for her.

It takes a good hour, hour and a half, to feed her every meal. And the nurses, they would come in and give me little pointers, about how to use a tiny spoon and, you know, talk to her and things like that—which I do, but it still doesn't help sometimes.

I feel that it is cheaper for the Government to have my mother here than it is for them to have her in a nursing home, no matter what.

My real feeling is this: She took care of us. And I know nursing homes are good, and some people have to have them. But as long as I can, she is home.

Chairman HEINZ. About one quarter of the home health care visits that Mrs. Bodie's physician ordered were denied because they were not considered to be medically reasonable or necessary.

Our next witness is Mr. John Schuh, age 79, from Uniontown, PA. Mr. Schuh had three heart attacks and needed care for his serious heart and diabetic conditions.

Mr. John Schuh.

STATEMENT OF JOHN SCHUH, UNIONTOWN, PA

Mr. SCHUH. After my first heart attack, why, the doctor told us that our traveling was very, very limited. We could travel down to see her sister in Monroeville or her other sister that lives down in Morgantown, WV. But now we cannot even do that, because I have had these three other heart attacks, why, my traveling is limited right to Uniontown.

Otherwise, why, we do not travel at all. We cannot go anyplace. After the first heart attack, why——

AIDE. How are you doing now, since your——

Mr. SCHUH. OK.

AIDE. OK now? How does the nurse help you?

Mr. SCHUH. Well, by coming here and taking care of—by taking a blood pressure, and examine us, and check my heart and everything like that. You would not believe our medication. Our medication runs anywhere between $400 and $500 a month. And I am not exaggerating.

AIDE. That must be something to manage.

Mr. SCHUH. It is. It is. I mean, with our income and that medication. At least I know last year our medication was over $5,000 for the year. This is why I keep my medication in the—I give you this here.

This here is two of them that I take at 5 o'clock in the morning with that Sorbitrate. Then this is what I take then at my breakfast time. Then I take this one here; that is my lunch. And then I—plus that one.

Mrs. SCHUH. Well, whenever the doctor prescribes a medicine or a new medicine, Toni—or sometimes we have another person come; it is usually Toni, but not always—they describe or tell us about the side effects and what to expect. And some of them we take every 6 hours, and she helps us understand that it is every 6 hours.

And the average layman just cannot imagine what we are going through. And the nurses explain it to us and make it in a layman's language so we can understand it.

We need the help and care of a nurse. There is no way we could afford it. No way.

Chairman HEINZ. Mr. Schuh's nurses taught him how to care for his heart condition; and how to manage his multiple medication, among other things. But that care was denied because it was not considered skilled care.

And by the way, Medicare does not pay for any of the $400 to $500 a month in drug costs.

Our next witness is Mr. Harvey Simms. He is 70 years old and lives in Freeland, PA.

He developed cancer of the larynx and needed home health care after his laryngectomy.

Mr. Simms.

STATEMENT OF HARVEY SIMMS, FREELAND, PA

AIDE. Well, Harvey was born with congenital cataracts and congenital deafness. He is legally blind and legally deaf.

Thn he developed cancer of the larynx. He went to the hospital, and they removed his larynx which is his voice box.

As you can see, he has the stoma, the opening there, which he will always have. And he will never be able to speak again.

And so that is where we came in. He came home from the hospital. We went to see Harvey to teach him how to take care of his stoma, and how to use his equipment.

When he first came home, it was a bit larger, and of course, it was swollen because of the surgery. And so he had to wash around it twice a day with soap and water. And you know, you cannot get any water inside—he could aspirate into the lung. So you have to be very careful.

And then he was putting a cream on it, like an antibiotic cream, because it was very red and sore. He had to do that at least twice a day.

And he wears this shield—you can see the plastic shield that he wears. He had to care for that. He washed that out with—he had a little brush and he would scrub it with peroxide and rise it out with water.

Harvey? Can you show these people what we taught you when you came home from the hospital, how to use the machines and how to take care of your throat? Can you show them? Go ahead and show them, Harvey.

Do you know what I mean? Why do you not show these people how this machine works; what we taught you? Can you show them how that works? Yeah; show them, Harvey.

[Demonstration.]

AIDE. OK, Harvey, show them how the suction machine works. It is a Yonker suction. And you have to put your thumb over this hole here, in order for a vacuum to form. And we had to teach Harvey to place it in his stoma, and place his thumb over the hole so it could suction out any mucous that would be in there.

You show them, too, Harvey.

[Demonstration.]

AIDE. You know, he has this equipment in his home. This was the stuff we had to teach him how to use, because he was going to be using it for the rest of his life.

Chairman HEINZ. Mr. Simms' home health care, which the nurses taught him, was denied because he was not considered homebound, even though he was so weak that he only left home for his radiation treatments, and only then, with his brother's aid.

Our last witness on the video is Mr. Harry Welling. Mr. Welling is 78 years old. He lives in Connellsville, PA.

He needed home health care for a terrible skin disease that created blisters over most of his body. He also fractured both hips, and is unable to leave the house without a great deal of assistance.

Mr. Welling.

STATEMENT OF HARRY WELLING, CONNELLSVILLE, PA

Mrs. WELLING. They gave him all kinds of medication, it must be for a couple of months; it did not do him any good at all. And he just kept breaking out in blisters. And then the blisters would break, and then they would go together. And he was a mess. Except, he did not have any on his face or his back; but every place else—his legs up here are purple from where he had these marks.

Well, finally the doctor decided to do a biopsy. And he sent it to Pittsburgh, and it was diagnosed as pemforglade.

So, he said, I cannot do anything more about that. He will have to go to a university hospital.

So he was there for 3 weeks. And when we took him in, and the doctor told me he was a mighty sick man, and in fact, he told his daughter that it could be fatal, because he really had a bad case of it.

AIDE. Tell me what his day is like. He comes down and then——

Mrs. WELLING. Well, he sleeps in here. You know, he sleeps in the hospital bed. Then he gets up, and I always bathed him, but I told him he was getting lazy, he was supposed to do that himself. I help him. And I have to put his shoes and socks on, because he cannot reach down to do that.

Well, then, when he comes out, he eats his breakfast, and comes in here and sits. Unless I take him for a walk. You see this one step up here. He cannot even get up there without help. I have to help him, or whoever is with me will help him. And coming down, the same way.

So it is kind of hard, you know, when there is just me.

Mr. WELLING. That chair there and over at the table there, I have to have my arm on the table, and this other arm catches the edge of the table, pull myself up.

Mrs. WELLING. What he means, he cannot just rise up from the chair like we do. He sits in that chair that you are in, because it is easier for him to get up than it is for him to push another chair back.

Sometimes he loses his balance, and he goes down, and then I have to go to a neighbor to help him up, because he cannot help himself up and I cannot lift him.

My brother-in-law that lives across the road usually comes over and lifts him up off the floor. And then he is real upset.

This is certainly a change from what he used to be. For about 74 years he was in good health; did everything, I mean. And then all of a sudden—you never know what is going to happen to you, do you, from one day to the next.

Chairman HEINZ. Mr. Welling's care was denied because he was not considered homebound.

Well, I would like to ask our witnesses to come forward and take their places at the witness table; that is Mrs. Sharon Mey and Rosemary Jenkins and Catherine Frasca, Marilyn Koch, and Thomas McElvogue.

Thank you very much for being here. We are delighted to have you.

I would like to ask Mrs. Mey and Mrs. Jenkins to be our leadoff witnesses.

Mrs. Mey.

STATEMENT OF SHARON MEY, FINLEYVILLE, PA

Ms. MEY. Senator Heinz and guests.

In 1974, my father, Frank Perry, had a stroke, which left him with aphasia, which means he could not talk; a weakened left side; no arm movement; and he walked with a cane.

My mother took care of him until she suffered a stroke in 1981, which left her bedfast and in a nursing home, where she died 15 days before my father.

After Mom's stroke, Dad settled in with me until his death. He was 78 years old.

Dad passed away in the hospital on May 10, 1986, after eight hospital trips since November 3, 1985, when he was diagnosed with liver disease, obstructed jaundice.

Since Albert Gallatin Home Health Nursing Service played such an important part in his life and mine, and since I would never have been able to keep him at home with us without their help, I am honored to make a support statement for them.

Only someone who has been in my position can fully understand the fear and frustration that I encountered in the last 7 months of Daddy's illness.

After Dad's hospital stay last November, the doctor told me that I would have a visiting nurse because he needed daily bandage changes and careful watching. I admit that my first thoughts were that this would be a big imposition and intrusion in my life. And believe me, I have never been so wrong.

My father was returned home to me in November with 6 days, 6 months, or 1 year to live. He had a catheter into the urinary bladder until such time that he could have a prostate operation; he had obstructed jaundice; orthostatic hypertension; a drainage tube out of his right side for bile drainage, or that is called a biliary oplification; lung disease; severe weight loss; a diseased liver which would eventually kill him; and an infection in his bladder.

He was prescribed seven medications with three to be administered around the clock. I was also told to measure all food and water intake, and water, urine and bowel output.

The nurses enabled me to keep my father with me until his death. They were a liaison between the doctor and myself in any

emergency. They drew blood once a week for the lab testing. They saved Daddy and I countless trips to the hospital for daily bandage changes; irrigation of the catheter; irrigation of the biliary tube.

They even helped me with the menus and countless other things.

The home health aide would bathe, shave and clean his nails; put fresh pajamas on him; and even change the bed if I wanted to.

When Dad was getting worse, Medicare cut back on home health nurse visits, from 7 days a week to only 3. And I was truly panic-stricken.

But the home health agency said, "Sharon, if you need us, call us; we will try to help." And they really did.

As I stated before, my mother died 15 days before my dad. I never told him that she was gone.

Albert Gallatin was the best support system to me at that time. Medicare started turning Dad down on visits in January and February, and it truly amazed me. No visits or materials were ever wasted in my home. But we struggled along until May 10 when Daddy died.

Visiting nurse services enabled me to keep my father at home in his own bed, and with his family around him. It may have been a lot of hard work, but it eliminated his going to a nursing home, like Mother.

My father was alert and aware of everything around him up until 4 hours before his died; and he wanted to be home. Albert Gallatin did that for him. And I feel that they enabled my father to die in peace and with dignity.

Chairman HEINZ. Mrs. Mey, thank you very much for a very—I know how difficult it must be to talk about——

Mrs. MEY. I got my wings today. I have never flown before. And this is the only reason I would ever get on a plane. [Applause.]

Chairman HEINZ. Thank you.

I am going to have some questions for you, but I want to hear from Mrs. Jenkins before I ask any further questions.

Mrs. Jenkins.

STATEMENT OF ROSEMARY JENKINS, BELLE VERNON, PA

Mrs. JENKINS. Thank you.

My name is Rosemary Jenkins, and I am the daughter of Robert Aiken who was 81 when he received Medicare home health services for 7 weeks, from February 21 to April 8, 1986.

During the last 2 years, Daddy's health was failing due to a weak heart and progressive Parkinson's disease. During the last year he suffered with TIA's, transient ascemic attacks, and pneumonia. That is why he was hospitalized.

From that time on he needed constant, 24-hour care. He was so weak he could not walk or eat on his own. He could not even turn in bed.

He lost control of his bladder and bowels. And at that time we were informed by the hospital social worker that upon release he would either have to go to an institution or come to our home.

If he came to our home, I was told he would be eligible to receive Medicare home health care, and physical therapy.

Since I am not trained in these services, and my husband is a 100-percent disabled veteran, the visiting nurses were a welcome relief.

We brought Daddy to our home on February 19. He was eligible for a hospital bed, and then we purchased the portable toilet and bedside table.

On February 21 the nurse came. She recorded Daddy's history and took his vital signs. The following week a routine was in force, with the aide coming Monday, Wednesday, and Friday, the nurse on Tuesday, and the physical therapist on Tuesdays and Thursdays.

The visiting nurse agency was on call 24 hours a day, and we needed the nurse in charge of Daddy's care to come an extra time because of a bladder problem.

The nurses were very kind to my Dad. Being able to look forward to these people coming brightened his spirits because they were his company.

Without this service it would have been necessary for us to take Daddy to a nursing home or some other institution which we would not have been able to afford very long. He did not want this, and I am sure he would have been quite unhappy there.

We were informed on May 5 that Medicare had decided Daddy should not have received as much skilled nursing care as he did. But I know he needed all the care he was given. And I received a second letter from Medicare saying they had looked at the case a second time and decided their original decision was wrong.

Daddy progressed with the care and therapy he was receiving. But he developed pneumonia a second time. He was readmitted to the hospital on April 8. He passed away April 24. I was glad that the denial came after he was gone, because I knew that he would not have been able to do it without the care he was getting from them.

The home health care he received made it possible for us to keep him with us rather than in a nursing home for the last few weeks of his life.

Chairman HEINZ. Thank you very much, Mrs. Jenkins.

As I understand the situation, the home health care that your father was receiving was considered medically unnecessary and was denied; is that correct? And then later, after he passed away, that care was reconsidered. And the earlier decision to deny the eligibility of that care was reversed; is that correct?

Mrs. JENKINS. Yes, it was.

Chairman HEINZ. You know, your two cases, unhappily, are not unusual. We had several instances presented in video today. There are literally thousands of other cases, like yours, where care has been denied, and then one way or another, that decision has, sometimes with great difficulty, been reversed. And there is clearly enough pain in the first instance, without having to worry about whether or not a father or mother is receiving, quote, "medically necessary," or in the case of the denials, what is believed by some people to be "medically unnecessary," care.

And I suppose one of the things that we need to get on the record is, really, what the human costs are that just do not get measured.

Now, Mrs. Mey, you were taking care of your father, Mr. Perry. And as I understand it, your mother was in a nursing home at the time.

Can you tell us why it was so important for you to provide the kind of care you did for your father despite the very large sacrifices you were required to make? Why did you feel it was so important to keep him at home?

Mrs. MEY. It is the saddest thing to see really good parents become so ill. Daddy could not talk. I would take him to the nursing home to see mother. And we were perfectly honest with him when we discovered she had cancer 2 years ago.

And he just wanted her taken care of and he did not want her to know he was sick. Then when this all started and Daddy got sick, I was so afraid that I would have to take him to that nursing home and he would see what she looked like. Because I know she did not even weigh 80 pounds. And if the two of them would have ever seen each other, it just would have broken their hearts. And I had one broken heart. And I could not do it to him. I really could not do it.

And I thought, as long as they will help me, I will take care of him. And I lied to him. I did not tell him when she died. You have to live through it. You to live through it.

And for them to come and say that we cannot come any more, and this person is near death; it is terrible.

Chairman HEINZ. Your mom died just a couple of weeks before your father passed away?

Mrs. MEY. Fifteen days before daddy. And I lied through that. And every day I would say that I had seen Mother, and that I would give him kisses from her. And when he was laying on his death bed——

Chairman HEINZ. That could not have been easy.

Mrs. MEY [continuing]. I said, "Daddy, I just saw Mother, and she gave me hugs and kisses." You have to. Those are the people that look care of you all your life. And they are deserving.

Chairman HEINZ. You needed and benefited from—and your father benefited from—that home health care in a lot of ways.

I understand that in addition to doing a lot of very important medically necessary procedures, and helping in a variety of ways, that the nurses also picked up his spirits quite a bit. Is that right?

Mrs. MEY. You know, they would come in his door, and I would meet them at the bottom of the stairs and tell them what the situation was. And these girls would come through his door, and they would say, "Hi toots; how are you today?"

And God love him, he was laying there so weak and so sick, they could make him smile. And when they gave him that bath and shaved him, it was like daddy was going to go to town.

It is so special. And it is needed.

Chairman HEINZ. What happened when those visits were cut back?

Mrs. MEY. I struggled. I was up all night. I lost 20 pounds. I did not eat. You know, you just lay in mortal fear that you are going to need them, and it will be the wrong day of the week.

Chairman HEINZ. If you had not had any of that home health care, none of it, what would you have done?

Mrs. MEY. Put him in a nursing home.

Chairman HEINZ. He would have had to go to a nursing home?

Mrs. MEY. I would have had to.

Chairman HEINZ. I guess the only other alternative would have been for you to hire private nurses, pay for it out of your own pocket. Could you have afforded that?

Mrs. MEY. No; I could not have afforded it. No; I could not have.

Chairman HEINZ. Could you have afforded to place him in a nursing home? Would he have had to go on Medicaid?

Mrs. MEY. He would have had to, yes. Mother was. What would the alternatives have been you know? And I just—it is a horrible thing when you have one in there, because nobody wants them in there. And I could not put him in.

Chairman HEINZ. And you were able to avoid that thanks to the home health care?

Mrs. MEY. Yes.

Chairman HEINZ. Mrs. Jenkins, thank you for your testimony.

You had a very similar experience to Mrs. Mey's. You also mentioned the expense of putting your father in a nursing home.

Would that have caused a financial strain on your family, too?

Mrs. JENKINS. Definitely. I am not employed, and my husband is a disabled veteran; he is not employed.

Chairman HEINZ. Well, where would you have been able to get the money?

Mrs. JENKINS. I do not know.

Chairman HEINZ. It sounds to me, just realistically, you could not have found the money to do that.

Now, you have indicated, I think very clearly, what that home health care meant to you and your father. Your father's care was obviously medically necessary. You talked about the tubes and how they had to be properly maintained, and the risk of infection, and so forth.

Is there any way you could have done that yourself?

Mrs. JENKINS. Well, my father had a catheter. And, no, I had no idea of how to take care of that; none whatsoever.

Chairman HEINZ. Did it make any sense to you when you learned that this care your father was receiving was considered medically unnecessary?

Mrs. JENKINS. No. In fact, the denial letter said that he received 12 more nursing skills visits than he had been eligible for. And he had not received 12 in total.

Chairman HEINZ. And all of these visits had been ordered by the physician; is that right?

Mrs. JENKINS. Yes.

Chairman HEINZ. And yet he was accused of having received more visits than he actually ever received?

Mrs. JENKINS. Yes.

Chairman HEINZ. How many did he receive? Do you remember?

Mrs. JENKINS. I think it was 11.

Chairman HEINZ. About 11?

Mrs. JENKINS. Total.

Chairman HEINZ. All I can say is, to both of you: I do not think, whether it is the fiscal intermediaries, or the agency who tells the fiscal intermediaries what to do, which is the Health Care Financ-

ing Administration—whether it is an agent of the Government or the governmental agency itself—I do not think they have any right to rewrite and reinterpret the law.

The law is that your father, Mrs. Jenkins, and that your father, Mrs. Mey, are entitled, under the law, to medically necessary home health care. And nobody, not even the President, has the right to rewrite a law that is passed and duly enacted in the Congress, as the Medicare law is. [Applause.]

And I can only apologize to you, as a Member of one of the three coequal branches of Government, that you had to—on top of what you went through as human beings and children, taking care of your parents—go through the added hardship that your Government imposed on you.

I thank you very much for having the courage to come here and tell us about it, and to take your first flight. [Laughter.]

Well, I am sure that after what you have been through, even that was a——

Mrs. MEY. Piece of cake.

Chairman HEINZ. We have several more witnesses. Catherine Frasca, who is the executive director of the South Hills Systems, is from my hometown, Pittsburgh, PA.

We have Marilyn Koch.

Ms. KOCH. Yes, sir.

Chairman HEINZ. And Tom McElvogue, who represents Blue Cross of Greater Philadelphia, the fiscal intermediary.

Before Ms. Frasca begins her testimony, I want to ask Gerald Shuttlesworth, who is the chief executive officer of the Albert Gallatin Visiting Nurse Association, to make some comments.

Jerry, I think most of the individuals on the video were basically clients of your association; is that correct?

Mr. SHUTTLESWORTH. Two of the four.

Chairman HEINZ. Two of the four.

The two that were yours are which ones?

Mr. SHUTTLESWORTH. Mr. Schuh and Mr. Welling.

Chairman HEINZ. As we learned, Mr. Schuh is 79 years old. He has got severe heart problems; severe difficulty walking and breathing; he tires easily. I guess he has to take—he showed us a great deal of medicine. We only got through lunch time as he was demonstrating that. And he was denied home health services because it was considered that he did not need the skills of a registered nurse.

Now, in your opinion, did Mr. Schuh need skilled nursing care and so qualify for coverage under the Medicare home health benefits?

STATEMENT OF GERALD SHUTTLESWORTH, MASONTOWN, PA, CHIEF EXECUTIVE OFFICER, ALBERT GALLATIN VISITING NURSE ASSOCIATION

Mr. SHUTTLESWORTH. Yes; there is no question that Mr. Schuh is a very ill individual. As you indicated, he is taking something like 11 different medications at all different frequencies. It is very difficult to sort out. He is very ill, and a person who clearly, under the Medicare regulations, needed skilled nursing care.

In fact, I believe you mentioned that the denial that we did receive on Mr. Schuh's care was appealed and has been reversed.

Chairman HEINZ. It was reversed?

Mr. SHUTTLESWORTH. On appeal, the intermediary has agreed that the care was covered care.

Chairman HEINZ. Now what was the original argument?

Mr. SHUTTLESWORTH. The original argument in Mr. Schuh's case was that there was no skilled care. It was a medical denial. And all of the nursing visits that we made to him in February and March were denied as——

Chairman HEINZ. On what was the allegation that this was not skilled care based; or was that unexplained?

Mr. SHUTTLESWORTH. Basically unexplained. When we receive a denial, we are told whether it is medical or technical and given a general reason. And in this case it was "no skilled care."

Chairman HEINZ. Was the nurse performing the skilled care a licensed nurse?

Mr. SHUTTLESWORTH. Oh, yes. A registered nurse was providing skilled care. On every visit we were doing a skill assessment, with an emphasis on his cardiopulmonary functioning.

As you can see, this individual has had four heart attacks. He is taking 11 different medications, 9 of them orally. He has a nitroglycerine patch that he wears, and takes PRN nitroglycerine. It is very difficult to monitor and sort out. And so on every visit the nurse was doing a skilled assessment and cardiac teaching, helping him to be aware of the signs and symptoms of problems, when to take some of those medications, and when to seek help. And there was very close biweekly interaction between our registered nurse and the physician. They actually sat down face-to-face every other week and discussed this case in detail and monitored it very closely.

So there is no question that it was skilled care.

Chairman HEINZ. Now, Mr. Welling was also one of your clients?

Mr. SHUTTLESWORTH. Yes.

Chairman HEINZ. And he was considered ineligible because he was not thought to be homebound; is that correct?

Mr. SHUTTLESWORTH. That is correct.

Chairman HEINZ. Now, he suffers from a terrible skin disease. He had broken both his hips. He was unable to walk.

On what basis did the fiscal intermediary consider him not to be homebound?

Mr. SHUTTLESWORTH. Frankly, I have no idea.

The patient could not, and still cannot, leave his home without substantial assistance. As far as the basis, as I have said, for the intermediary's determination that he is not homebound, I really have no idea.

Chairman HEINZ. He is unable to leave home without assistance; is that correct?

Mr. SHUTTLESWORTH. That is right. He is unable to negotiate even a single stair step.

It is obvious that the fiscal intermediary or HCFA is interpreting homebound status in a way that is much more restrictive than it has been in the past.

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You should also know that the denial on Mr. Welling's care was also reversed upon appeal.

Chairman HEINZ. We have got two cases here, but there are others, I gather?

Mr. SHUTTLESWORTH. Oh, there are a lot of others, yes.

Chairman HEINZ. Are many of them similar to these?

Mr. SHUTTLESWORTH. Yes, most of them are similar. In fact, we have been providing home health care for about 7½ years. And in the 7½ years that we have provided home health care services—and that is up through the spring of this year—we have provided something like 400,000 Medicare visits.

Chairman HEINZ. So you are not inexperienced, ignorant, or naive?

Mr. SHUTTLESWORTH. I do not think so.

During that period of time, 7½ years and 400,000 visits, we had only 9 visits denied.

Chairman HEINZ. Well, what happened that suddenly you are having a significant number denied?

Mr. SHUTTLESWORTH. Well, that is what we have been asking ourselves.

We have really been doing nothing different, except to be more careful. We have gotten a little gun shy. As I told you, prior to April, out of 400,000 visits, we have had 9 visits denied. Since April we have had over 1,000 visits denied.

And it is very difficult to determine, from any home health agency's point of view, what to do, because the changes are unannounced. The interpretations seem to be capricious and arbitrary.

And it is very difficult, as a provider of home health services, to know how to respond in that environment.

Chairman HEINZ. The bottom line question I have for you is: During the last year, you went from 9 denials in 7½ years, to 1,000 just in the last few months. Is the result of all of that that, for whatever reasons, a lot of Medicare beneficiaries are now going without needed home health care?

Mr. SHUTTLESWORTH. There is no question.

Chairman HEINZ. And just not getting the kind of care that was so important to Mrs. Mey and Mrs. Jenkins?

Mr. SHUTTLESWORTH. There is no question that beneficiaries in need of care are being denied care to which they are entitled.

People are being forced back into more expensive forms of health care delivery. People are going without care.

Home health agencies, really regardless of their size or their track record, are at a point in time where they are struggling for survival.

The combination of pressures that have been placed on home health agencies in the past 6 months, 6 months to a year, which include the cuts under Gramm-Rudman; the lowering of cost caps; the disaggregation of cost caps; and now, wholesale denials will make it impossible for home health agencies to survive in the future.

And if they are unable to survive, or the services that they provide are curtailed really any more, I think the impact on the Nation's elderly population is going to be absolutely devastating.

Chairman HEINZ. Mr. Shuttlesworth, thank you very much.

Did you also fly over here today?

Mr. SHUTTLESWORTH. I flew over last night. I earned my wings awhile back.

Chairman HEINZ. Would you reassure Mrs. Mey that it is possible to survive a round trip?

Mr. SHUTTLESWORTH. She said if she survived this, she would have no worries about getting home.

Chairman HEINZ. Thank you very much.

Mr. SHUTTLESWORTH. You are welcome.

Chairman HEINZ. Catherine Frasca.

STATEMENT OF CATHERINE FRASCA, EXECUTIVE DIRECTOR, SOUTH HILLS HEALTH SYSTEMS, PITTSBURGH, PA

Ms. FRASCA. I want to say first of all, I am very grateful that you are having this hearing, and for affording me an opportunity to present the provider's point of view.

In my 20 years experience in the home health industry I have never been confronted with the size, scope, and complexity of issues and problems that now threaten the very survival of the home health industry.

Since these issues are varied and widespread, I will attempt to focus on four components of one major issue, Medicare claim denials.

As we have heard: One, home care providers have significant increases in the number of Medicare claims denied for payment; two, these denials are coming at a most critical time, when we are receiving sicker patients with increasing health care needs.

Under the current prospective payment system, patients are leaving the hospital earlier in a more intense phase of their illness, requiring a multiplicity of specialized services that must be provided by experienced, qualified home care staff.

So at a time when the demand for home health services is increasing, and home care patient needs are expanding, the ability of Medicare patients to access these needed home care services is diminishing.

Three changing interpretations of long-standing Medicare regulations without adequate clarification being given to providers. Providers have increasing concerns regarding who is eligible, and what constitutes a reimbursable home care visit.

For example, it has been my understanding, since the inception of the home care benefit, under the conditions of participation, that the intent of Congress was to determine eligibility for home health services based on medical necessity rather than on the need for Federal cutbacks of Medicare home health expenditures.

Within the past year, it appears as though the intent of Congress has been radically changed by arbitrary and capricious interpretations of the Medicare statute relating to homebound, intermittent and skilled care.

This drastic change has occurred swiftly, resulting in disruption in home care operations, and placing both providers and consumers in extremely vulnerable positions.

To date, little, or no information has been provided to justify or to clarify the continuing reinterpretation of homebound, intermittent and skilled care.

Four, there is no realistic way for providers to appeal these denials, and there are many difficulties with the appeals process. The regulations are unclear and inconsistently interpreted.

In addition, an inordinate amount of time is required to complete the necessary paperwork, thus usurping vital staff time and increasing the cost per visit.

The length of time before a final decision is reached is excessive—more than 1 year. For the most part, providers do not have the right of appeal, nor are we permitted to appeal or assist the beneficiaries on their behalf.

And yet our staff are left with the impossible task of attempting to explain and to help the patient and family comprehend why the medically needed services, certified as necessary by their attending physician, are being denied coverage by the fiscal intermediary.

And now the patient or family must somehow muster their energy to enter a highly complex and burdensome legal process. And quite frankly, as many home health agencies can attest, the patient often dies somewhere between the denial, the initial contact of the patient's family with the Social Security Administration, the actual filing of the appeal, and so on and so on.

The real result is that, tragically, the patient's medical health care needs may go unmet while the bureaucratic wheel churns on.

Is this really what Congress intended?

In conclusion, denying reimbursement of vital home health services to the beneficiary will result in the exacerbation of their illness and eventual deterioration of their overall physical well being, thereby requiring a more costly level of care and placing the Medicare beneficiary at risk.

Home health agency providers do not believe this is the intent of Congress, and strongly urge that HCFA reassess the current claims denial process in concert with the home health industry to establish a more realistic claims review and denial process that will more appropriately serve the needs of Medicare beneficiaries.

Thank you.

[The prepared statement of Ms. Frasca follows:]

PREPARED STATEMENT OF CATHY FRASCA

Mr. Chairman, members of the committee, ladies and gentlemen: I am Cathy Frasca, executive director of the South Hills Health System Home Health Agency, a very large non-profit, multihospital-based home health agency in Pittsburgh, Pennsylvania. I am grateful to Senator Heinz and to the Senate Special Committee on Aging for having this hearing and for affording me an opportunity to present the home care providers' point of view with input from the National Association for Home Care, Pennsylvania Association of Home Health Agencies, Division of Ambulatory Care of the American Hospital Association, and Hospital Association of Pennsylvania.

In my 20 years experience in the home health industry, I have never been confronted with the size, scope, and complexity of issues and problems that now threaten the survival of the home health industry. Since these issues are varied and widespread, I will attempt to focus on four components of one major issue—Medicare claim denials.

I. HOME CARE PROVIDERS HAVE SIGNIFICANT INCREASES IN THE NUMBER OF MEDICARE CLAIMS DENIED FOR PAYMENT

For example, 76 home health agencies responded to a survey conducted by the Pennsylvania Association of Home Health Agencies in June, 1986 regarding claims denials from September, 1985 through April, 1986. Of the 112,122 patients billed 2,989 patients were denied. There were 1,338,525 visits billed, of which 15,848 visits have been denied.

II. THESE DENIALS ARE COMING AT A MOST CRITICAL TIME WHEN WE ARE RECEIVING SICKER PATIENTS WITH INCREASING HEALTH CARE NEEDS

Under the current prospective payment system, patients are leaving hospitals earlier in a more intense phase of their illness, requiring a multiplicity of specialized services that must be provided by experienced, qualified home care staff. At a time when the demand for home health services is increasing and home care patient needs are expanding, the ability of Medicare patients to access these needed home care services is diminishing.

III. CHANGING INTERPRETATIONS OF LONG STANDING MEDICARE REGULATIONS WITHOUT ADEQUATE CLARIFICATION BEING GIVEN TO PROVIDERS

Providers have increasing concerns regarding who is eligible and what constitutes a reimbursable home care visit. For example, it has been my understanding since the inception of the home care benefit under the Conditions of Participation that the intent of Congress was to determine eligibility for home health services based on medical necessity rather than on the need for federal cutbacks of Medicare home health expenditures.

Within the past year, it appears as though the intent of Congress has been radically changed by arbitrary and capricious interpretations of the Medicare statute relating to homebound, intermittent and skilled care. This drastic change has occurred swiftly, resulting in disruption of home care operations, and placing both providers and consumers in an extremely vulnerable position. To date, little or no information has been provided to justify or to clarify the continuing reinterpretations of homebound, intermittent and skilled care.

IV. THERE IS NO REALISTIC WAY FOR PROVIDERS TO APPEAL THESE DENIALS AND THERE ARE MANY DIFFICULTIES WITH THE APPEAL PROCESS

The regualtions are unclear and inconsistently interpreted.

In addition, an inordinate amount of time is required to complete the necessary paperwork, thus, usurping vital staff time and increasing the cost per visit.

The length of time before a final decision is reached is excessive—more than one year. For the most part, providers do not have the right of appeal, nor are we permitted to appeal or assist the beneficiary on their behalf—but, yet our staff are left with the impossible task of attempting to explain and/or help the patient and family to comprehend why the medically needed services certified as necessary by their attending physician are being denied coverage by the fiscal intermediary—and *now* the patient and/or family must somehow muster their energies to enter a highly complex and burdensome legal process, and, quite frankly, as many home health agencies can attest, the patient often dies somewhere between the denial, the initial contact of the patient and family with the social security administration, the actual filing of the appeal, and so on, and so on. The real result is that, tragically, the patient's medical health care needs may go unmet while the bureaucratic wheel churns on. Is this what Congress intended?

In conclusion, denying reimbursement of vital home health services to the beneficiary will result in an exacerbation of their illness and eventual deterioration of their overall physical well-being, thereby requiring a more costly level of care and placing the Medicare beneficiary at risk.

Home health agency providers do not believe this is the intent of Congress and strongly urge that HCFA reassess the current claims denial process in concert with the home health industry to establish a more realistic claims review and denial process that will more appropriately serve the needs of the Medicare beneficiary.

Thank you for affording me an opportunity to present a few of the providers' concerns to this prestigous committee.

ADDENDUM TO TESTIMONY

This addendum contains additional information that should be included with my testimony presented to the Senate Special Committee on Aging in Philadelphia, PA on July 28, 1986.

Several points that were not included in my prepared testimony due to limited time constraints are as follows:

(1) There will be no resolution of the Medicare claims denials crisis until all HHS and HCFA transmittals, guidelines, or program instructions including any medical screening parameters are subject to public notice under the Administrative Procedures Act, and once implemented, applied henceforth and not retroactively.

(2) F.I.s should be required to respond to all provider or beneficiary requests regarding claims denials including re-opens as well as recons/appeals, etc. within clearly delineated and reasonable time frames. Time constraints must be equitably applied to both F.I.s and home health agency providers.

(3) The current practice engaged in by HCFA and the F.I.s of issuing denials to patients who are very much in need of skilled care is creating widespread hardships among elderly citizens and requiring enormous sacrifices on the part of their families and friends. This is of particular significance when the beneficiary is declared liable with little or no information or guidance accompanying denial notices. The SSA appeals form along with appropriate instructions should, at least, accompany each beneficiary denial.

(4) The entire beneficiary liability issue should be investigated; questions need to be addressed and resolved relating to why a beneficiary should be expected to know they did not qualify for Medicare home health services when these services had been requested by a qualified physician and provided by a Medicare certified home health agency.

(5) The value of home health care to the individual recipient and his or her family should not be minimized. Rather than the currently narrowing focus of interpretation, the regulations should be interpreted more broadly to allow any Medicare beneficiaries who are victims of serious long term illnesses to be cared for in the ideal setting of their own homes. Some examples of the types of cases which currently benefit from care in the home are AIDS and ventilator dependent persons and others whose disease process has left them too weak and disabled to cope without additional support.

(6) Medicare beneficiaries must be assured that they will each receive care that is adequate, safe, and that affords continuity from one level of care to another.

(7) HHS, HCFA, and the F.I.s should carefully coordinate service coverage among the various Medicare programs to maximize each recipient's benefits and minimize the currently existing gaps/overlaps in coverage i.e., end stage renal disease.

(8) It should be the responsibility of each F.I. to conduct joint educational workshops with HCFA regional representatives to ensure that providers have a clear understanding of any guidelines relating to home care coverage, documentation, and other related issues. Similar informational conferences geared more for consumers should also be provided for Medicare beneficiaries.

I believe that the intent of Congress is to provide a home health benefit for Medicare subscribers. At a time when sicker patients could be most appropriately cared for in their homes, their home care coverage is being denied. If the present environment continues, both the Medicare beneficiary and the home health agency provider will be placed at risk, and the end result will be a complete dismantling of the home care Medicare benefit.

Thank you for the opportunity to include these comments as an addendum to my testimony.

Chairman HEINZ. Cathy, we thank you very much.

Ms. Koch.

STATEMENT OF MARILYN KOCH, ACTING REGIONAL ADMINISTRATOR, HEALTH CARE FINANCE ADMINISTRATION, PHILADELPHIA, PA

Ms. KOCH. Mr. Chairman, I am glad to be here today. And I will try to abbreviate my remarks a bit in the interest of time.

Chairman HEINZ. Your entire set of remarks will be a part of the record.

Ms. KOCH. It has been submitted for the record, yes.

During the 1980's we witnessed a dramatic growth in home health services. This growth stems primarily from changes in Medicare which, beginning with the enactment of the Omnibus Reconciliation Act of 1980, removed certain payment, coverage, and participation restrictions.

This legislation significantly expanded the Medicare home health benefit by removing the limit on the number of covered home health visits, eliminating the requirements for a prior hospital stay, eliminating the deductible, and allowing more proprietary home health agencies to participate in the program.

Even though home health expenditures constitute only slightly more than 3 percent of overall Medicare expenditures, they are growing very rapidly. From 1973 to 1980 Medicare payments for home health care increased at an average annual rate of about 33 percent.

Medicare home health expenditures doubled between 1980 and 1983, from $800 million to $1.6 billion, before rising to nearly $2.4 billion in 1985.

They are projected to reach $4 billion by 1990.

Pennsylvania's rate of home health expenditures during this period parallels the national experience, rising from $53.6 million in 1980 to $173.6 million in 1985.

The legislative changes made by the Omnibus Reconciliation Act have also increased utilization of home health services by Medicare beneficiaries.

Since 1980, the annual number of home health visits provided to Medicare patients has grown by 78 percent, from 23 million in 1980 to 41 million visits in 1984.

In 1984, 1.5 million beneficiaries received home health services, compared to less than 1 million in 1980.

In Pennsylvania, the growth in numbers of home health visits since 1980 exceeds the national average, growing 90 percent from 2.1 million visits in 1980 to 4 million visits in 1984.

Along with the legislative changes and the growth in home health use, we have seen a concomitant growth of 110 percent in the number of participating home health agencies, from about 2,900 in 1980 to about 6,000 so far in 1986.

In Pennsylvania, there are now a total of 278 home health agencies, compared to only 105 in 1980.

Thus there appears to be a relationship between the supply of the service and the demand.

Medicare, as originally enacted, is an acute care program with services designed to support this concept. Consistent with this principle, Medicare's home health benefits are oriented toward a need for skilled care.

The benefits were designed to be part of a continuum of care in an acute episode, usually following hospitalization.

The Medicare home health benefit is not a long-term care benefit for chronically ill individuals, nor does it pay for social services, such as homemaker's services or meals on wheels.

Under the Medicare home health benefit, the following types of services are covered: Part-time and intermittent nursing care provided by or under the supervision of a registered professional nurse; physical, occupational, and speech therapy; medical social

services which contribute significantly to the treatment of a patient's health condition; that is, such services are needed because social or emotional problems impede medical treatment; part-time and intermittent services of a home health aide; and medical supplies—other than drugs and biologicals—and medical appliances.

The Medicare law limits payment for home health services to those beneficiaries whose conditions are of such severity that the individuals are under the care of a physician; confined to their homes; and in need of skilled nursing care on an intermittent basis; or are in need of physical or speech therapy.

The care must be prescribed by a physician, and the services must be provided by a participating home health agency in accordance with the physician's plan of treatment.

Daily skilled nursing and aide services have never been considered to meet the statutory requirement of intermittent need. Guidelines have always restricted coverage of daily care to a short period of time to conform to the requirements for intermittent care.

We are aware of the heightened interest in all Medicare posthospital benefits. That interest has increased as a result of implementation in 1983 of Medicare's prospective payment system for hospitals.

The positive incentives within PPS for efficient management of health care resources have resulted in a significant drop in hospital lengths of stay, and have prompted an appropriate transfer of care from the inpatient hospital setting to various outpatient settings.

HCFA is committed to paying for all home health care covered under the provisions of the Medicare statute. Nevertheless, a number of studies conducted by the General Accounting Office and HCFA's Bureau of Quality Control, from 1981–84, indicated that between 27 and 34 percent of all home health visits billed to Medicare were medically unnecessary or not covered by the program.

The most recent study we conducted projected payments for noncovered care in fiscal year 1984 at $597 million. If this rate were to continue unabated, an additional $4.1 billion would be paid by Medicare for noncovered care between 1985 and 1989.

To assure that only medically necessary services, are furnished to beneficiaries by home health agencies, and that this is occurring in a manner consistent with the direction of both Congress and the GAO to improve administration of the home health benefit, we have undertaken a number of activities.

Among the activities underway to strengthen the administration of the benefit is a realignment of the home health agency claims processing structure.

First, we are reducing the number of fiscal intermediaries servicing freestanding home health agencies from 47 to 10. This reduction will result in improved consistency in coverage determinations among fiscal intermediaries.

Second, to further reinforce consistency among intermediaries, HCFA is now requiring home health agencies to complete a uniform set of informational forms for all fiscal intermediaries to use in making payment determinations.

The new home health forms, developed with extensive input from the home health industry, are designed to assure that all in-

formation necessary to make appropriate medical review determinations is supplied by home health agencies when the claim is first submitted.

While these new reporting forms may temporarily increase payment time in some areas, we expect their use to result in more uniform and accurate payment determinations.

Finally, we are looking at other ways of delivering health care that might provide a better mix of services or improve delivery mechanisms to address the changing needs of our beneficiaries.

For example, under the social health maintenance organization demonstration, we are testing whether providing a broad array of both medical and social services to patients will enable them to maintain their independence within the community and forestall institutional care.

The results of this demonstration will not be available for several years.

We believe, however, that the best potential for making services available to our beneficiaries under alternative programs lies with capitated health care systems such as health maintenance organizations and competitive medical plans.

Under recently implemented provisions that provide financial incentives for HMO's and competitive plans to enroll Medicare beneficiaries, we have seen a rapid growth in plan participation and Medicare enrollment.

Under these plans beneficiaries often receive more benefits than under the traditional Medicare Program with lower out-of-pocket costs.

By the beginning of July 1986, over 667,000 beneficiaries were enrolled in these programs, which are attractive to beneficiaries and providers alike. In Pennsylvania, almost 20,000 beneficiaries have been enrolled in these programs.

We want to build on the success of our HMO/CMP Program by permitting Medicare beneficiaries to use a voucher to purchase the health insurance coverage most appropriate to their needs. A bill has been introduced that would accomplish this.

The voucher proposal would foster competition among health care plans as they market their particular benefit package to beneficiaries in their area.

The plans would be paid a prospectively determined rate for providing services that need not follow the traditional Medicare benefits scheme, but must be worth an equivalent amount.

We believe that both beneficiaries and health insurers will be attracted to the voucher system.

In conclusion, let me assure you that we are committed to seeing that Medicare beneficiaries receive all necessary care which is covered by the program.

The increase in expenditures and utilization for home health care attests to the continued demand for and provision of home health services.

Our activities are directed at assuring that appropriate, medically necessary care is provided which meets the postacute definition of home care services as spelled out in the law.

[The prepared statement of Ms. Koch follows:]

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Prepared Statement of Marilyn Koch

Mr. Chairman and members of the Committee. I am pleased to be here today to discuss home health care under the Medicare program.

BACKGROUND

During the 1980's we have witnessed a dramatic growth in home health services. This growth stems primarily from changes in Medicare which, beginning with enactment of the Omnibus Reconciliation Act of 1980 (ORA), removed certain payment, coverage, and participation restrictions. This legislation significantly expanded the Medicare home health benefit by removing the limit on the number of covered home health visits, eliminating the requirement for a prior hospital stay, eliminating the deductible, and allowing more proprietary home health agencies to participate in the program.

Even though home health expenditures constitute only slightly more than three percent of overall Medicare benefits, they are growing rapidly. From 1973 to 1980, Medicare payments for home health care increased at an average annual rate of about 33 percent. Medicare home health expenditures doubled between 1980 and 1983, from $800 million to $1.6 billion, before rising to nearly $2.4 billion in FY 1985. They are projected to reach almost $4 billion by FY 1990. Pennsylvania's rate of home health expenditures during this period parallels the national experience, rising from $53.6 million in 1980 to $173.6 million in 1985.

The legislative changes made by ORA have also increased utilization of home health services by Medicare beneficiaries. Since 1980, the annual number of home health visits provided to Medicare patients has grown by 78 percent from 23 million in 1980 to 41 million visits in 1984. In 1984, 1.5 million beneficiaries received home health services compared to less than one million in 1980. In Pennsylvania, the growth in numbers of home health visits since 1980 exceeds the national average, growing 90 percent from 2.1 million visits in 1980 to 4 million visits in 1984. The number of beneficiaries served rose from 91,000 in 1980 to 135,000 in 1984.

Along with the legislative changes and the growth in home health use, we have seen a concomitant growth of 110 percent in the number of participating home health agencies, from about 2,900 in 1980 to about 6,000 so far in 1986. The majority of this growth has been in the number of proprietary home health agencies, which now number about 2,000, up from just under 165 in 1980. In Pennsylvania, there are now a total of 278 home health agencies, compared to only 105 in 1980. Proprietary home health agencies make up about 30 percent of the total, as opposed to 5 percent in 1980. Thus, there appears to be a strong relationship between supply and demand.

Before discussing current Medicare home health issues and describing our initiatives in this area, I would like to describe briefly the scope of the Medicare home health benefit.

THE MEDICARE HOME HEALTH BENEFIT

Medicare, as originally enacted, is an acute care program with services designed to support this concept. Consistent with this principle, Medicare's home health benefits are oriented toward a need for skilled care; the benefits were designed to be part of the continuum of care in an acute episode, usually following hospitalization. The Medicare home health benefit is not a long term care benefit for chronically ill individuals, nor does it pay for social services such as homemaker services or meals on wheels.

Under the Medicare home health benefit, the following types of services are covered:

Part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

Physical, occupational or speech therapy;

Medical social services which contribute significantly to the treatment of a patient's health condition; that is, such services are needed because social or emotional problems impede the medical treatment;

Part-time or intermittent services from a home health aide; and

Medical supplies (other than drugs and biologicals) and medical appliances.

The Medicare law limits payment for home health services to those beneficiaries whose conditions are of such severity that the individuals are under the care of a physician, confined to their home (homebound) and in need of skilled nursing care on an intermittent basis, or in need of physical or speech therapy. The care must be

prescribed by a physician, and the services must be provided by a participating home health agency (HHA) in accordance with the physician's treatment plan.

Daily skilled nursing and aide services have never been considered to meet the statutory requirement of intermittent need. Daily aide or nursing services have never been covered over an extended time period and guidelines have always restricted coverage of daily care to a short period of time to conform to the requirement for intermittent care.

HEIGHTENED INTEREST IN HOME HEALTH

Mr. Chairman, we are aware of a heightened interest in all Medicare post-hospital benefits. That interest has increased as a result of the implementation, in late 1983, of Medicare's prospective payment system (PPS) for hospitals. The positive incentives within PPS for efficient management of health care resources have resulted in a significant drop in hospital lengths of stay and have prompted an appropriate transfer of care from the inpatient hospital setting to various outpatient settings.

Other factors contributing to the heightening of interest in home health services include the aging of the American population, the growing sophistication of home health services that expands the kinds of illnesses that can be treated at home, and State-specific changes in licensure and certificate of need requirements that have encouraged proliferation of home health facilities.

IMPROVED ADMINISTRATION

HCFA is committed to paying for all home health care covered under the provisions of the Medicare statute. Nevertheless, a number of studies conducted by the General Accounting Office (GAO) and HCFA's Bureau of Quality Control (BQC) from 1981-1984 indicated that between 27 and 34 percent of all home health visits billed to Medicare were medically unnecessary or not covered by the program. The most recent study we conducted projected payments for noncovered care in FY 1984 at $597 million. If this rate were to continue unabated, an additional $4.1 billion would be paid by Medicare for noncovered care between FYs 1985-89.

The findings of these successive studies, coupled with the escalation in Medicare home health expenditures and utilization, make it imperative that only medically necessary services are furnished to beneficiaries by home health agencies. To assure that this is occurring in a manner consistent with the direction of both the Congress and GAO to improve the administration of the home health benefit, we have undertaken a number of activities.

Let me describe just a few of these.

HOME HEALTH INITIATIVES

Among the activities HCFA has underway to strengthen the administration of the Medicare home health benefit is a realignment of the HHA claims processing structure. First, we are reducing the number of fiscal intermediaries (FIs) serving freestanding HHAs from 47 to 10. This reduction will result in improved consistency in coverage determinations among fiscal intermediaries. The final notice implementing this requirement, which was mandated under the Deficit Reduction Act of 1984, was published in the Federal Register in February 1986.

Second, to further reinforce consistency among intermediaries, HCFA is now requiring HHAs to complete a uniform set of informational forms for all FIs to use in making payment determinations. The new home health forms—developed with extensive input from the home health industry—are designed to assure that all information necessary to make appropriate medical review determinations is supplied by HHAs when the claim is first submitted. While these new reporting forms may temporarily increase payment time in some areas, we expect their use to result in more uniform and accurate payment determinations. Computerized screens have been developed in conjunction with the new reporting forms and are now being tested. When the screens are in place nationally, planned for early 1987, the amount of work necessary for intermediaries to conduct medical reviews of home health claims will be greatly reduced.

We have also modified the way we calculate home health cost limits to reflect more accurately the actual experience of home health agencies. To ease the transition from previous cost limits, we are phasing in the limits over three years beginning last July 1, when the limits were set at 120 percent of the mean. Beginning July 1, 1986, the limits are set at 115 percent of the mean and will be set at 112 percent of the mean beginning July 1, 1987.

In addition, both fiscal intermediaries and State survey officials will begin making home visits in FY 1987. These visits are intended to help ensure the provision of quality health care and HHA compliance with program requirements affecting patient care. They are also meant to help prevent HHAs from submitting claims for unnecessary or uncovered services.

ALTERNATIVE DELIVERY MECHANISMS

Finally, we are looking at other way of delivering health care that might provide a better mix of services or improve delivery mechanisms to address the changing needs of our beneficiaries.

For example, under the Social Health Maintenance Organization demonstration, we are testing whether providing a broad array of both medical and social services to patients will enable them to maintain their independence within the community and forestall institutional care. The results of this demonstration will not be available for several years.

We believe, however, that the best potential for making services available to our beneficiaries under alternative programs lies with capitated health care systems such as health maintenance organizations (HMOs) and competitive medical plans (CMPs). Under recently implemented provisions that provide financial incentives for HMOs and CMPs to enroll Medicare beneficiaries, we have seen a rapid growth in plan participation and Medicare enrollment. Under these plans, beneficiaries often receive more benefits than under the traditional Medicare program with lower out-of-pocket cost. And, they welcome the opportunity provided by HMOs/CMPs for case-managed care. Providers are paid prospectively established rates and are rewarded for efficient operation. Since April 1985, we have entered into 137 contracts with HMOs/CMPs in 31 States. By the beginning of July 1986, over 667,000 beneficiaries were enrolled in these programs, which are attractive to beneficiaries and providers alike. In Pennsylvania, almost 20,000 beneficiaries have been enrolled under five contracts.

We want to build on the success of our HMO/CMP program by permitting Medicare beneficiaries to use a voucher to purchase the health insurance coverage most appropriate to their needs. A bill has been introduced that would accomplish this. This voucher proposal would foster competition among health care plans as they market their particular benefit packages to beneficiaries in their areas. The plans would be paid a prospectively determined rate for providing services that need not follow the traditional Medicare benefit scheme, but must be worth an equivalent amount. We believe that both beneficiaries and health insurers will be attracted to the voucher arrangement.

CONCLUSION

In conclusion, let me assure you that we are committed to seeing that Medicare beneficiares receive all necessary care covered by the program. The increase in expenditures and utilization for home health care attests to the continued demand for and provision of home health services. Our activities are directed at assuring that appropriate, medically necessary care is provided which meets the postacute definition of home care services, as spelled out in the law. We continue to investigate improved approaches to meeting the needs of our beneficiaries and believe that capitated health care plans offer enormous potential for the future.

Chairman HEINZ. Thank you. Mr. McElvogue.

STATEMENT OF THOMAS McELVOGUE, VICE PRESIDENT, GOVERNMENT RELATIONS AND SPECIAL PROJECTS, BLUE CROSS OF GREATER PHILADELPHIA

Mr. MCELVOGUE. Good morning, Mr. Chairman.

My name is Thomas McElvogue, and I am vice president of government and special programs for Blue Cross of Greater Philadelphia.

I wish to thank you for allowing Blue Cross the opportunity today to testify on our participation in the administration of the Medicare Program and its impact on home health agencies that we serve.

Since 1966 Blue Cross of Greater Philadelphia has served as an intermediary for the Medicare Program. In this role it proved to be one of the most successful public/private partnerships ever constructed.

Currently, the plan serves nearly 500 providers including over 300 home health agencies in Pennsylvania and Virginia.

The role of the intermediary is to insure that the administration of the program is consistently and uniformly provided, and the providers which have either been nominated or assigned to the intermediary are provided the appropriate information and guidance to insure that benefits are made available to the medical beneficiary.

The Health Care Financing Administration generally divides our function in four major categories: claims processing; program safeguards; beneficiary and provider services; and productivity investments.

Two areas—claims processing and program safeguards—comprise the lion's share of our resources and costs. Claims processing obviously includes those activities necessary to process and pay timely and accurately claims for Medicare covered services.

The intermediary's major accountabilities are to ensure that the claim forms are understood and properly submitted, and then to process those claims through a myriad of screens and edits, both automated and manual, to ensure that the services are covered and that the beneficiary is e titled to them.

We perform these functions in accordance with the law, regulations, and detailed operating instructions which are issued by HCFA.

The processing of Medicare claims also provides the foundation for all other program safeguard activities. It is also critically important that the intermediary develop a cost-effective program that utilizes an effective automated processing system and has the flexibility of adapting to numerous changes that are required due to legislative or administrative policy revisions.

The program safeguard category includes such functions as reimbursement audits, medical review determinations, and ensuring that Medicare is a secondary payor whenever other similar payors should be primary.

Within the scope of the reimbursement audit cycle, the intermediary is required to set an appropriate and reasonable rate, interim rate, that providers will receive for services that are rendered to beneficiaries.

The intermediary is accountable to the Medicare Program for ensuring that this rate is set at a reasonable level to ensure that there is no over- or underpayments on the part of the program.

At the end of the fiscal year, the intermediary is required to perform a cost report audit to guarantee that only the reasonable costs as determined by the regulations and instructions have been paid on behalf of the program.

This audit and reimbursement function has been applied uniformly and has been beneficial to both the Government in generating savings and to providers in knowing what costs are allowable and reimbursable under the program.

We have worked closely with the Pennsylvania and Virginia Association of Home Health Agencies to develop educational pro-

grams dealing with new policies and in reinforcing other principles of reimbursement.

The intermediary is also required to review the medical appropriateness of claims submitted for payment. The manner in which an intermediary reviews medical claims for medical appropriateness has varied considerably over the past few years.

The home health review process has changed dramatically during fiscal year 1986. It first began in October. Prior to September, the intermediary developed a set of medical review screening parameters that reflected acceptable medical practices in those areas served by Blue Cross of Greater Philadelphia.

All Medicare home health claims were passed through this set of automated screening parameters, and any claim that failed these predetermined standards was sent to our medical review department for a detailed analysis by our professional staff of our registered nurses and physicians to ensure uniform and consistent application of Medicare regulations.

The review also required additional medical information from the provider to be utilized in determining the medical appropriateness of the services that were provided.

Then in September of 1985, a new medical information form for home health care was developed by the Health Care Financing Administration, and was required as an attachment to all initial home health bills and each subsequent 60-day recertification bill.

The intermediary was then required to review each of these medical information forms when they were submitted. This new process resulted in a far more extensive professional review of expanded medical information of home health claims than had been the practice prior.

As a result of this extensive review process the number of denials has increased significantly. This has been the experience of Blue Cross of Greater Philadelphia as well as other intermediaries in the Nation.

It is reasonable to expect such an increase in denial since the intermediary is reviewing in detail many more claims with much more specific medical information.

In addition to the increase in the number of Medicare denials, the transition to this process was a difficult one for all of us. HCFA, the intermediaries, home health agencies, and the beneficiaries.

However, after a lengthy implementation period, the HHA's are experiencing a better cash flow that was the result of HCFA and the intermediary working together.

The intermediary's performance—our performance—in completing these functions is monitored carefully by HCFA through the Contractor Performance and Evaluation Program. This program has been in effect since 1980 and has been modified considerably during that time.

Currently, there are 90 standards which we have to live by, 16 of which have been deemed as critical in performance of our contractual responsibility with the Government.

These 16 critical elements include such standards as maintaining a cost-effective system for claims processing, administering a cost-effective provider audit program which is defined as returning $5

in savings for every $1 spent; administering a cost-effective medical review program that also is defined as $5 in savings for every $1 spent; but also ensuring accurate medical review determinations and that claims are subject to an appropriate level of medical review.

There are obviously other standards as well, but I just cite a few.

Since HCFA has been monitoring and evaluating our performance, we have never failed to meet any of the critical elements, and have in fact met all of the performance criteria.

As a result of this performance, Blue Cross of Greater Philadelphia was designated as the statewide intermediary for all free-standing home health agencies in Pennsylvania, 1982, when HCFA determined that it was in the best interest of the program to designate regional intermediaries.

In making the selections, HCFA used a variety of evaluation criteria, including our ability to make accurate medical review determinations; determine accurate cost interpretations; and also to serve the provider community and beneficiary community.

As a result of this evaluation, Blue Cross was designated as the regional intermediary. When HCFA decided to reduce the number of contractors from 49 to 10, Blue Cross of Greater Philadelphia had been selected to serve all free-standing home health agencies in Maryland, Delaware, West Virginia, and the District of Columbia, in addition to those currently served in Pennsylvania and Virginia.

We recognize the importance of the Medicare home health benefit to the beneficiary throughout this region. We commend the committee for its efforts to review the complex and difficult issues relating to the Medicare home health benefits, and stand ready to assist the Health Care Financing Administration in seeking new and better ways to serve the Medicare beneficiary.

Thank you.

Chairman HEINZ. Thank you very much, Mr. McElvogue.

It is difficult to know where to start with all these very expert witnesses, and some people who have actually been on the firing line as well.

But let me just ask Ms. Koch: Since we implemented the DRG's, there has been a 37-percent increase in the number of people discharged to home health care. Now, that is not at all unexpected.

The whole purpose of DRG's was to get people out of the hospital into less restrictive, less costly care settings.

In your testimony, you state that there has been an increase in the cost of home health care to the Federal Government. Is not that increase only to be expected in view of the shift in our payment system for hospital from retrospective to prospective?

Ms. KOCH. Some if it is. It is very difficult to tease out the causes there.

Because simultaneous with the prospective payment effect, you have the cumulative effect of the changes that were made in the benefit itself; that is, the removal of the 3-day prior hospital stay, for example.

So now you have services being delivered that never would have been delivered under prior law.

Chairman HEINZ. But that is the whole point of moving to the prospective payment system. We want to encourage use of less costly home health care services than continued services at $500 to $700 a day in the hospital.

Ms. KOCH. Yes. My point is that you cannot attribute the entire increase in that cost to the prospective payment system. Part of that increase in cost also is attributable to new and expanded benefits.

While you cite a 37-percent increase in the number of cases going to a home health agency, that 37-percent increase over what had occurred before still accounts for only about 1 percent of all hospital discharges.

Chairman HEINZ. Well, what is the relevance of that number?

Ms. KOCH. The relevance of that number is in the total number of patients coming out of the hospital, if one patient comes out of the hospital and goes to a home health agency and, as a result of PPS, two patients come out of the hospital and go to a home health agency, you have had a 100-percent increase.

Chairman HEINZ. Yes.

Ms. KOCH. As against the total number of hospital discharges, that increase is far less noticeable. And against the total number of hospital discharges, the number of patients being discharged to home health care still is about 1 percent

Chairman HEINZ. I understand all that. I just do not understand how that helps answer the question of what is wrong, given the change to prospective payment, with greater utilization of home health care. We should be expecting it, and indeed, we should welcome it; not believe that there is some kind of a terrible plot to defraud the Federal Government. [Applause.]

Ms. KOCH. Senator, my testimony did not suggest that it was wrong; only that it was large.

Chairman HEINZ. It is a significant increase. But the question that I would like you to answer, which is the thrust of my earlier question, is: What judgment do you make about whether it is inappropriately large?

Are you saying that it is inappropriately large, or just that it is large, as indeed, was expected?

Ms. KOCH. My testimony did not suggest it was inappropriately large, nor have I made such a judgment. Our judgment is that we should be paying for care as presently defined in the law; that is, skilled intermittent service, to a homebound patient.

Chairman HEINZ. Let me ask Cathy Frasca this.

Cathy, you are not exactly a neophyte here. As I understand it, you helped draft the original conditions for participation in this program; is that right?

Ms. FRASCA. I did particpate in providing input and clarification for the original conditions of participation.

Chairman HEINZ. How can you be so young-looking with all that experience behind you?

Ms. FRASCA. Thank you.

Chairman HEINZ. That is not the question I wanted to ask you. [Laughter.]

In your view, has there suddenly been a change in the way Medicare guidelines on homebound, intermittency, and skilled care are being interpreted?

Ms. FRASCA. In the 20 years that I have been in home care, I felt that I understood what was an eligible admission to home care; today, I am at a complete loss, because there are continuing changes in the interpretation and application of the law, as it was written.

And I feel it is very necessary that all HHS and HCFA transmittals, guidelines, or program instructions, including any medical screening parameters, should be subject to public notice under the Administrative Procedures Act, and that once implemented, should be applied henceforth, and not retroactively.

We have to have rules. I do not know how to operate without rules. [Applause.]

And right now I have no guidelines to operate with, under the present system.

Chairman HEINZ. Ms. Koch, what do you say to that?

Ms. KOCH. The instructional material is frequently not published under the Administrative Procedures Act, but it is published——

Chairman HEINZ. Wait a minute. The instructional procedure is frequently not published under the Administrative Procedures Act.

Do these instructional materials come after a decision has been made?

Ms. KOCH. The instructional materials supplement regulations, and they are submitted to the industry for prior consultation. While every home health agency may not receive them, the major industry groups do receive them——

Chairman HEINZ. Now, let us just analyze this for a minute.

What you are saying is, HCFA changes the rules. And then, after they have changed the rules on January 1, 1986, then sometime after that, something called instructional material may or may not get to Cathy Frasca or Jerry Shuttlesworth.

It is submitted to some national group, to which they may or may not belong.

Are they required to belong to some national group?

Ms. KOCH. They are not required to belong to some national group. Final instructions do reach them. The prior consultation process is for the draft to be amended to incorporate industry views.

Chairman HEINZ. Now, if the rules are changed effective on January 1; the instructional materials get to the home health providers when? When is Cathy Frasca going to get this so-called instructional material? A month, 2 months, 3 months later?

Ms. FRASCA. As one provider, I am still waiting.

Chairman HEINZ. No, wait. I am interested when she thinks you are going to get it.

Ms. KOCH. In some cases it will be received before it is implemented. In other cases, it will follow shortly after. I do not know the individual cases Cathy refers to.

Chairman HEINZ. Any cases where it just shows up a lot later, or never shows up at all? Any of those?

Ms. KOCH. There may very well be the rare case where the instruction that is sent to an individual home health agency goes to

the incorrect address, or is returned by the post office, or is chewed up by the mail.

Chairman HEINZ. I do not think that you have totally convinced everybody that the instructional materials get in.

But let me ask, Jerry or Cathy, what is the situation on this instructional material? Are you receiving it on a timely basis?

Mr. SHUTTLESWORTH. No, in many cases we receive nothing. We simply find out about changes by way of denials. And usually, when decisions are made, they are applied retroactively to us. So there is really no way to defend yourself in that situation.

Chairman HEINZ. Now, let me just ask Ms. Koch, so I understand the situation.

You did say that sometimes these notices go out after the effective date; is that right?

Ms. KOCH. They will be received in the hands of agencies after the effective date.

Chairman HEINZ. Right. Now, by what stretch of the imagination of fairness, equity, or any other reasonable standards for judging the behavior of people in high places, by which I mean you and your agency, is it right to get something to somebody saying, you know, you are supposed to jump 2 feet high as of 3 weeks ago, and penalize them for not having done so in the intervening 3 weeks?

What is right about that?

Ms. KOCH. If I may use an example, we ordinarily do not penalize retroactively or penalize immediately——

Chairman HEINZ. Do you consider a denial penalization?

Ms. KOCH. The form 485 is an example of where we did instruct the intermediaries to allow a learning curve at the introduction of that form.

I should also point out that——

Chairman HEINZ. I am sorry; I did not understand that.

Ms. KOCH. The implementation of the form 485 was brought on with a learning curve at the time that was implemented, so the denials were not made immediately.

Chairman HEINZ. Well, just answer my question, though. Is it right to deny these benefits before these people have gotten the information? I mean, I am not accusing you of doing anything wrong. I am just asking whether it is or not?

Ms. KOCH. Senator, the coverage instructions have not been altered and have not been altered in some time. So the instructions in terms of what constitutes homebound and what constitutes intermittent have been out there and in the hands of the industry for quite some years.

Chairman HEINZ. Well, let me read you a kind of interesting transcript. You know, we talked to a lot of home health care agencies and fiscal intermediaries in preparation for this hearing. And we received transcripts from, in this case, one conversation between a home health care provider and its fiscal intermediary, questioning what homebound means according to today's interpretations.

And I will just read you part of this. This is the home health agency responding: Quote:

How am I going to know then who is the right patient here? This man cannot leave the home without the assistance of another person and the help of some devices, and he has an old stroke; one side with no use; vision impaired.

I am really surprised. I mean, I do not know anything about home health anymore. I did OK until now.

Tom McElvogue, does that conversation, or ones like it, sound familiar?

Mr. MCELVOGUE. Well, we had a professional staff of registered nurses and physicians that deal on a daily basis with the medical review. And one of the prerequisites of those folks is that they have experience in the home care field.

And this kind of a conversation, I am sure, takes place on a regular basis between our staff and home health agencies. The unfortunate part, I think, right now is that we can only make determinations based on the information that is made available to us in this medical information form.

I think as has been demonstrated here today by Jerry's two statements about the individuals that we saw on the video, and Ms. Jenkins, that when decisions are made based on that information, and additional information is sent in to us, and we review it on the professional level, and there is more and better information, we will reverse the decision and process the claim for payment.

So I think it is a situation where all of us, among the agencies, the intermediary, and the Government, are trying to work through a dramatic change in the way the claim is processed. And that is, due to the introduction of this new form.

I understand that because of those studies that Marilyn talked about in 1984, the Health Care Financing Administration felt that there was, according to these studies, misappropriation. And as a result of that, we have seen a new medical information form that is being implemented on a national basis and should be uniformly and consistently applied.

But I think that you will see that kind of a situation probably more frequently than we would like, and I am sure more frequently than the agencies would like.

But until we get through a more—longer period of time in learning the proper use of this form, I think we are probably going to have those kinds of conversations.

But we are trying to give as much information to the agencies as we can so we can make this as smooth a processing system as possible.

Chairman HEINZ. Well, I will come back to the 485's in a minute. But leaving that set of issues aside, are you getting the information you need in a fashion that is clear and timely? And in your view, are your clients, the home health care agencies, getting the information they need in order to submit claims that are appropriate and proper?

Mr. MCELVOGUE. Well, we get a tremendous amount of information from the Government, particularly, health care financing and operating instructions. We get that information, and that which is part of the home health operating manual, we get those out to them the moment it comes in. It is a very important part of our contractual responsibility to get that information out as quickly as we receive it.

There are, on occasion, delays; there is no question about that. But we do the best that we can to get it out. And in most cases, it is not retrospective.

I will not say that you are getting a lot of leadtime. But generally speaking, there is some leadtime.

Chairman HEINZ. How much?

Mr. MCELVOGUE. Well, not enough, as far as we are concerned.

Chairman HEINZ. How much?

Mr. MCELVOGUE. It would depend on the individual circumstances. In the 485 form, we probably had 4 to 6 months to get all the information out to the agencies and to conduct some training sessions.

Again, we would have liked to have more time. But it seemed to be enough, at least initially.

Chairman HEINZ. And what examples do you have of insufficient time?

Mr. MCELVOGUE. More from the intermediaries role. We get a lot of instructions that suggest, as of the first of the month, something will change; and it may not come in until the end of the month. But in many cases, that is just——

Chairman HEINZ. Let us just make sure I understand that. You are saying, you may get an instruction that says, as of June 1, things are going to be judged this new way. And you receive that late in June.

Mr. MCELVOGUE. Late in May.

Chairman HEINZ. Late in May. At which point, you have a few days to inform the home health agencies, and they have no time to train and instruct their people?

Mr. MCELVOGUE. What happens many times is that the instructions we get on late notice like that is internal operating instructions for us, and not so much directly impacting the home health agencies.

Chairman HEINZ. Do those so-called direct operating instructions to you have an impact on the home health care agencies?

Mr. MCELVOGUE. Not in making coverage determinations, generally?

Chairman HEINZ. No?

Mr. MCELVOGUE. No.

Chairman HEINZ. Have there been any changes in definitions of homeboundness, intermittency, or skilled care?

Mr. MCELVOGUE. No.

Chairman HEINZ. So they are the same today as they were 3 years ago, 4 years ago?

Mr. MCELVOGUE. Yes.

Chairman HEINZ. Do you agree with that, Cathy?

Ms. FRASCA. If I have been doing something wrong for 20 years, then, no one has called it to my attention.

Chairman HEINZ. Jerry Shuttlesworth.

Mr. SHUTTLESWORTH. I would agree.

Chairman HEINZ. Well, now, why is there such a discrepancy between what you say, Mr. McElvogue, and what Ms. Frasca and Mr. Shuttlesworth say?

Mr. MCELVOGUE. Well, I can deal—I served as the intermediary with Mr. Shuttlesworth. And I guess the point that I can only go

back to is the fact that the process has changed this year versus other years.

In other years, we the intermediary had the discretion of looking at what we thought to be inappropriate care. At least those claims that did not fit what we considered to be parameters of acceptable home health care.

And as a result of that, we only looked at a given percentage, a low percentage, of home health claims.

With the implementation of this new form, we have to look at many more claims. With looking at more claims with more information—because of the information form that is put in——

Chairman HEINZ. That is all well and good, but it does not describe how an agency that in 7½ years has had nine denials suddenly has thousands of them. Have they been doing things wrong for the past 7½ years?

Mr. MCELVOGUE. Not according to what we were paying for.

Chairman HEINZ. I do not understand. Can you explain? Because first you said nothing has changed; "skilled" has not changed; "intermittent" has not changed; "homebound" has not changed. You say that Jerry wasn't doing anything wrong for the past 7½ years. But where I really lose you is, now, suddenly he is.

Mr. MCELVOGUE. Well, what I think could possibly have occurred is the fact that we did not look at many, or possibly, any of his claims during our review period; or very few.

Chairman HEINZ. What were you being paid for?

Mr. MCELVOGUE. Well, our review process used the screening parameters that generally drop 11 percent on average of claims that were submitted to us.

Chairman HEINZ. Eleven percent?

Mr. MCELVOGUE. Of the total, yes, sir.

Chairman HEINZ. And how many claims did you get from Mr. Shuttlesworth in a year?

Mr. MCELVOGUE. Thousand a month, I guess.

Mr. SHUTTLESWORTH. About a thousand, 1,200 a month?

Chairman HEINZ. A thousand a month? That is 12,000 a year. Eleven percent of that will give you at least two standard deviations, probably three standard deviations worth of certainty. Which is 99 percent certainty that you are going to be within a minuscule plus or minus, 1 or 2 percent.

I do not understand how suddenly he could be so far off.

Mr. MCELVOGUE. Well, we only used an average of 11 percent. He may not have been in there. But it is reasonable to assume that some of his claims would have been in there, and that some of those were reviewed——

Chairman HEINZ. At Blue Cross, you are experts on statistics. You have statisticians, and if you do not, you can go to the University of Pennsylvania and rent one for a couple of hours, who will make sure that you have a good sampling algorithm to do everything that you ought to do.

Either that, or you have not been doing your job. And you look like you have been doing your job. Right?

Mr. MCELVOGUE. Yes, sir.

Chairman HEINZ. So, since you have been doing your job, all this balderdash about, well, we were not sampling all of them does not

mean a damn thing. You were doing a statistically significant sample that was dynamically determined. And a whole bunch of smart people thought it was the right thing to do.

Now, what is going on? Nothing has changed, and yet everything has changed?

Mr. MCELVOGUE. Well, the change that has occurred is just that we are looking at so many more claims now, with such given information.

Chairman HEINZ. I mean, the only rational explanation I can come up with—and I do not suggest this is the truth—but the only rational explanation, if I accept what you say as fact, is that somehow Jerry Shuttlesworth managed to submit of his roughly 11 percent, a bunch of phony claims that were good ones, and hiding the real claims that were inappropriate.

Mr. MCELVOGUE. No, no, I think what we can——

Chairman HEINZ. Have you been hiding the others, Jerry?

Mr. SHUTTLESWORTH. No.

Mr. MCELVOGUE. We could take a look at—when we were looking at 11 percent of the claims, we just had a claim form in front of us. That claim went to a professional to review it on a medical basis. We called Jerry and Jerry gave us possibly the entire medical record.

Based on that entire medical record, we were making decisions that allowed for him to have very few denials. Now, because we have to make an initial determination off this 485 form, the limited information available to us allowed us to deny the case there.

As he indicated, on recon, on these several cases that he sent in for appeal, the decision with more medical information allowed us to reverse the decision and pay the claim properly.

Currently, Jerry's denial rate is less than 2 percent of all the visits that he sends in. And again, that is before we have an opportunity to possibly review any appeals that he might have sent in.

Chairman HEINZ. Let me take a step back and ask Ms. Koch this:

Is there any doubt in your mind that in the transition to all these form 485's that there are a rising number of instances where people who are entitled under the law to benefits, such as Mrs. Mey's and Mrs. Jenkins' fathers, are wrongly being denied benefits?

Ms. KOCH. One of the reasons behind those forms was a finding that in the past there——

Chairman HEINZ. Now, wait a minute; I am not asking about the forms. I am asking a question, for you to make a judgment here.

Ms. KOCH. Well, my judgment depends on the historical experience.

Chairman HEINZ. Now, I do not want historical experience. I want you to answer a direct question. Which is: Are people now being denied their entitled benefits in a way that was never true before; yes or no?

Ms. KOCH. Senator, on an initial determination of the claim coming in the door, based on the documentation presented with the case, it is possible.

I would argue that on reconsideration, they are not.

Chairman HEINZ. We will talk about that in a moment.

But you are saying that, yes, there are a lot more people who are being initially denied, even though they should not be.

Now, you are also saying that on reconsideration, you make it right.

What percentage of claims reconsidered are approved?

Ms. KOCH. I do not have that information in my memory. I can get it for the record.

Chairman HEINZ. Well, then, how can you make the preceding statement that you made?

Ms. KOCH. On the basis of two cases that we listened to this morning——

Chairman HEINZ. You judge something on the basis of two cases?

Ms. KOCH. No.

Chairman HEINZ. All right. Now, you are dealing with a very large universe. And you are saying to me, a U.S. Senator, chairman of the Aging Committee, "Senator, do not worry, we may be denying people in the first instance, but they are getting reversed on reconsideration," and you do not know what proportion of them are being reversed; is that right?

Ms. KOCH. I know that 98 percent of the claims being submitted are being paid; and that percentage is roughly the same as it was prior to the introduction of these——

Chairman HEINZ. That is not what you testified to a minute ago. That is some other fact.

I am asking for the basis for the judgment that you made a moment ago. Now, what is the basis for the judgment?

Ms. KOCH. I am suggesting that in a very small universe of denials, reconsiderations——

Chairman HEINZ. Well, it is not very small for Mr. Shuttlesworth.

How many denials have you had in the last few months?

Mr. SHUTTLESWORTH. Over a thousand visits in the past few months.

Chairman HEINZ. That is a thousand people. That is a thousand Mrs. Jenkinses and a thousand Mrs. Meyes. Those are real people with real problems. And that is one agency. [Applause.]

And you are saying, it is small. And furthermore, you still are not answering my question. Which is—you said; I did not put the words in your mouth—you said that reconsideration makes it right. And that everybody is getting the due help upon reconsideration. And you do not have anything to base that on because you do not even know what proportion is being reconsidered.

The answer is 21 percent. Twenty-one percent. About one out of every five are approved on reconsideration.

Now, of those that fail reconsideration and are appealed to an administrative law judge, what proportion is overturned?

Ms. KOCH. Senator, I did not get the denial percentages before I came out here today. I would be happy to supply them for the record.

Chairman HEINZ. Well, it might be helpful for you to know that you were judged to be wrong 55 percent of the time when you deny reconsideration; 55 percent of the time. That is a high batting average. It means, you are striking out 55 percent of the time on behalf of people who need help.

Now, is it easy for a homebound person to get reconsideration or pursue action through an administrative law judge?

Ms. KOCH. It is relatively easier for that person to obtain the reconsideration than to follow through with the administrative law judge.

Chairman HEINZ. Do you remember the fellow who could not talk and could not see there? Remember that fellow, Mr. Simms? It is easy for him? What is he supposed to do?

Ms. KOCH. I did not say it was easy for him. I said it was relatively easier for the reconsideration than it was for the administrative law judge proceeding.

Chairman HEINZ. Relatively easier?

Ms. KOCH. Yes, what he is to do is to file a form requesting reconsideration——

Chairman HEINZ. He cannot see; he cannot speak. Let's take hypothetical.

I am in need of home health care. I have gone to Cathy or Jerry or somebody. And they say, well, we cannot help you. You cannot walk. You are sick. You need skilled nursing care, but we do not know what these people are going to do. We just cannot take the chance. We lost $10,000 last month we did not have. And we do not have a line of credit from Mellon Bank that we can count on, since we are getting paid by the Federal Government, and the Federal Government is only $215 billion in debt this year, and that is a bad credit risk.

Now, what am I supposed to do? Tell me what I do to file for reconsideration? Who do I call?

Ms. KOCH. You talk to your fiscal intermediary.

Chairman HEINZ. I do not know a fiscal intermediary from anybody. I am sick. I just got out of the hospital. I had a heart attack. I had a stroke. I ain't feeling so good. My head hurts. My eyes are blurry; I have cataracts. And what is this—what do I do with this fiscal intermediary? What do I do, call him up? Say, hello, get me Mr. McElvogue? I mean, what do I do?

Ms. KOCH. You follow, as with all other claims for services which are denied, whether home health or any kind of claim——

Chairman HEINZ. Do I fill out a form, is that the first thing I do?

Ms. KOCH. Yes, sir.

Chairman HEINZ. I fill out a form. Where do I get the form?

Ms. FRASCA. Forms are not included with a denial.

Chairman HEINZ. Ms. Koch—I will yield to Cathy Frasca in a moment—but you say, I get a form, somehow, from some place—fill it out, send it in to him.

Cathy Frasca what do I do?

Ms. FRASCA. I am going to let Joanne Parzick answer that, because she has been involved in this more closely than I, and we have approximately 200,000 home visits a year, and have had serious problems with denials.

Ms. PARZICK. The beneficiary must get information from the Social Security department or office, which oftentimes takes weeks. But it falls to the home care providers to explain this to the beneficiaries that do not understand.

Chairman HEINZ. So, you cannot give them a form? Is that right?

Ms. PARZICK. No, we cannot. We cannot appeal, or even assist them to appeal.

Chairman HEINZ. So I have to find a Social Security office.

Ms. PARZICK. That is right.

Chairman HEINZ. If I am a resident of the hill district, I am really out of luck because they are closing that Social Security office.

Ms. PARZICK. Right.

Chairman HEINZ. And I have got to find out where the downtown Pittsburgh Social Security office is.

Ms. PARZICK. That is right.

We have booklets that we sent for which took months to receive, so that we could give them to the patients and family; they are not easy to come by; there are instructions in those.

And just getting the appropriate form—I went through the process myself to see how hard it was. I went through a mock one. It took weeks, and I had filled out the wrong form three times, and I am a professional.

Chairman HEINZ. That is what you claim. [Laughter.]

Mr. Shuttlesworth, do you claim to be a professional too?

Mr. SHUTTLESWORTH. Yes.

Chairman HEINZ. Is it that hard?

Mr. SHUTTLESWORTH. It is that hard. It is very difficult to understand the process.

Chairman HEINZ. It seems really incredible that it could be that hard. I am not questioning your veracity, but Ms. Koch has just said all I have to do is—it is easy.

Mr. SHUTTLESWORTH. It is very difficult, particularly when there is no one to assist the Medicare beneficiary. The home health agency is not able to assist.

The other dynamic is that the majority of patients who have had visits denied, if they are astute enough to figure out this process, are intimidated and afraid to go through the appeal process, because they are afraid that their Medicare benefits will be eliminated totally. [Applause.]

Chairman HEINZ. There are some additional questions I am going to submit to some of you for response in writing. There is a question I want to submit to Mr. McElvogue, for example, on what he thinks about the cost-effectiveness of reviewing every form. I understand you have some reservations about it.

And the record will reflect that he does have some reservations about the cost-effectiveness of it. In spite of the fact it is being done for reasons of cost-effectiveness.

I have been, I hope, civil but tough-minded in my questioning of you, Ms. Koch. If I have in any way been disrespectful, I apologize. But I really must say that I do not see that the policies you were sent down here to defend are very defensible. And you have done your best to defend an absolutely untenable position, as far as I can tell.

But I do not want to be hard on you, personally. I mean, you are a representative of HCFA and the way it is reacting to all of this.

Is there anything you would like to say in conclusion for the record here?

Ms. KOCH. You know, I think in conclusion I would say that particularly the homebound and intermittent requirements are among the most difficult that we have to administer.

And we are trying very hard to administer them equitably, given the present statutory scheme.

Chairman HEINZ. Well, the present statutory scheme, as I understand it, liberalized those benefits?

Ms. KOCH. Yes, in terms of the prior hospital stay, requirement and number of covered visits.

Chairman HEINZ. The central question that is unanswered, at least satisfactorily within a commonsense meaning of that term, is: Why, if we expected an increase in discharges to home health care because of PPS and DRG's, why if Congress anticipated that and liberalized the law, why, if definitions of "intermittent," "homebound," and "skilled" have not changed—other than the fact that every single claim is being subject to scrutiny that is wrong 55 percent of the time—why do we have the problems before us today?

Ms. KOCH. Senator, I would characterize those judgments as very, very difficult to make. And indeed, the cases that get before an administrative law judge are probably the most preplexing of what are professional judgment calls.

So a 50-percent reversal rate, or a 20-percent reversal rate, or, for that matter, a 100-percent reversal rate, does not leave me with the sense that something is going wrong, but rather, that something is going right, and we are being overturned where we ought to be.

Chairman HEINZ. If you assume that this easy-to-follow process of reconsideration and appeal is, as a practical matter, in any sense of the term, available to anything other than just a few persistent, relatively healthy, determined, stubborn people who are going to fight the system or else.

Now, I hope that one of the things that HCFA has learned from this discussion, and there will be other occasions, is that the appeals process is not accessible to the average beneficiary. Indeed, it is strongly prejudiced against them. Even the fiscal intermediaries, and Mr. McElvogue represents one of the 10 regional FI's are saying, "Hey, your system really needs a lot of improvements. Things here are not right." They are echoing what the home health care agencies are saying. The conclusion of all these people is that Medicare beneficiaries in need of care, most importantly of all, are being hurt.

Now, I do not know how many thousands of people like Mrs. Jenkins, and like Mrs. Mey, it would take to convince the Health Care Financing Administration that people are being hurt, but there are thousands just in Jerry Shuttlesworth's agency.

Jerry, you were 1 of 300 agencies in the State, and we are 1 of 50 States.

So what to you is just a change from 1 percent to 2 percent in the number of Medicare claims, is in fact tens of thousands of people who are in impossible situations to begin with, who are being trampled upon by their Government. And that is not what Government ought to be doing.

So, I thank you all for being here.

The hearing is adjourned.

[Whereupon, at 12:30 p.m., the committee adjourned, subject to the call of the Chair.]

APPENDIX

Material Related to Hearing

Item 1

THE PENNSYLVANIA ASSOCIATION OF HOME HEALTH AGENCIES

Mary Kay Pera, Executive Director
Patricia Rawding, President

2400 Park Drive
Harrisburg, PA 17110
(717) 657-7605

THE PENNSYLVANIA ASSOCIATION OF HOME HEALTH AGENCIES (PAHHA), a private, nonprofit organization located in Harrisburg, represents the majority of the Commonwealth's Medicare-certified home health agencies.

Members of the PENNSYLVANIA ASSOCIATION OF HOME HEALTH AGENCIES include voluntary nonprofit, community agencies (43%); private nonprofit, community agencies (11%); agencies associated with hospitals or nursing homes (22%); and proprietary agencies (24%).

Founded in 1971, the Association seeks to increase recognition of the vital role of home health care, to promote better understanding and appropriate use of home health services, to help build better and closer relationships among all those who provide health care, and to give its members a unified voice on issues that concern them. To protect the quality of home health services, the Association supports adherence to a specific set of standards and to a code of ethics.

The Association provides educational workshops and semiannual conferences; it monitors legislative and regulatory matters for its members and studies the issues. It publishes pertinent reports, papers, news and analysis. It represents its members' interests through its seat on the Governor's Medical Assistance Advisory Committee (MAAC) of the Pennsylvania Department of Welfare, through the Home Health Subcommittee of the MAAC, and through participation in other statewide advisory groups.

PURPOSE OF THE PENNSYLVANIA ASSOCIATION OF HOME HEALTH AGENCIES

(1) To promote cooperation and to develop high professional and ethical standards which enhance the quality of home health services among member agencies so as to provide increased home health care to the public at reasonable cost;

(2) To shape public policy with respect to appropriate regulation, licensing and reimbursement of home health agencies, to assure recognition of home health services as a vital cost-efficient segment of the total health care industry;

(3) To adopt and achieve common goals to improve understanding and utilization of home health services; and

(4) To direct public opinion through dialogue, debate, planning, education and research toward an appreciation of the role of home health agencies.

PENNSYLVANIA ASSOCIATION OF HOME HEALTH AGENCIES
2400 Park Drive
Harrisburg, PA 17110
(717) 657-7605

FACTS ABOUT HOME CARE

WHAT IS HOME HEALTH CARE? Home health care is any or all of a range of health care and social services offered to patients in their homes. From birth at home to care for the dying, it is for those who, under a physician's guidance, can be treated at home rather than in an institution.

WHAT SERVICES DO HOME HEALTH AGENCIES OFFER?

- Professional Health Care: Most home health agencies offer the following services: Skilled nursing care; physical occupational, speech, and respiratory therapy; family counseling; dietary guidance; medical social services and maternal and child health care. In addition, technology permits many agencies to offer chemotherapy, intravenous antibiotics, intravenous and tube-fed nutrition and apnea monitoring. The patient's physician directs the individualized plan of treatment carried out by the professional home health agency staff.

- Home Health Aides: Home health aides provide the additional personal care and assistance that are often required. Aides work under the direction of the home health nurse.

- Hospice: Hospice care is for the terminally ill. It usually includes treatment for pain in addition to other services.

- Other: Home health care also includes adult day care, respite care, meals at home, the provision of medical supplies, drugs and medical equipment, and health promotion.

WHO RECEIVES HOME CARE? Home health care is for those who need it: young, old, rich, poor, chronically or acutely ill or disabled.

WHO PAYS FOR HOME HEALTH CARE? Home health care services are paid for by Medicare, Medicaid, the Veterans Administration, Blue Cross and other commercial insurers. Coverage depends on the specific policy.

HOW MANY AGENCIES ARE THERE IN PENNSYLVANIA? According to April 1986 statistics from the Pennsylvania Department of Health, Pennsylvania has 290 Medicare-certified home health agencies.

HOW MANY PEOPLE RECEIVE HOME HEALTH CARE? Pennsylvania Association of Home Health Agencies' members will make over four million visits this year.

WHO REPRESENTS PENNSYLVANIA'S MEDICARE-CERTIFIED AGENCIES? The Pennsylvania Association of Home Health Agencies is the statewide, nonprofit trade association representing the Commonwealth's Medicare-certified agencies.

Item 2

NATIONAL ASSOCIATION FOR HOME CARE
PRESS★RELEASE

FOR IMMEDIATE RELEASE

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UPDATED STUDY CONFIRMS WILLFUL DISMANTLING OF MEDICARE HOME HEALTH BENEFITS

WASHINGTON, D.C., JULY 21, 1986.....
The National Association for Home Care today released a revised and updated report on the deliberate attempted destruction by the Administration of the Medicare home care benefits. The release of the report entitled, "The Attempted Dismantling of the Medicare Home Care Benefit," was scheduled to coincide with a field hearing conducted in Philadelphia by Senator John Heinz, Chairman of the U.S. Senate's Special Committee on Aging.

The report, which originally was issued in March, 1986, has been updated to include new data and information about the Administration's continued attack on the Medicare benefits for the nation's elderly during the first half of 1986. Additional case studies, documenting unfair claims denials, provide incontrovertible evidence of intentional disregard of the pressing home health needs of America's older citizens.

The new information included in the report confirms the devastating effect Administration home health care policies are having on both the recipients and providers of home care services. Citing specific actions undertaken through administrative policy changes, the report details efforts of the Health Care Financing Administration to curtail the availability of home health services to the elderly under Medicare.

"On the occasion of this hearing, I wish we were able to report that the elderly, in spite of being sent home from hospitals

quicker and sicker under the DRG system, were able to receive adequate and necessary Medicare covered home care services. We can't!," said NAHC President Val J. Halamandaris. "The truth is that because of Administration initiatives, amounting to bureaucratic lawlessness, the patients are being caught in the middle of an impossible situation. They can't and don't want to stay in the hospitals, but they need more home care than Medicare provides." According to Halamandaris, "The compounded effect of the ill-considered actions detailed in this report is to shred the essential 'safety net' of home care for Medicare patients."

The report, "The Attempted Dismantling of the Medicare Home Care Benefit", is based on extensive research into the Administration's public policies and actions affecting home care; and responses to a survey questionnaire sent to all Medicare-certified home health agencies in the country at the end of 1985. The survey covered the two years, 1984 and 1985, during which the prospective payment (DRG) reimbursement system for Medicare participating hospitals has been in effect. Approximately 40% of those agencies receiving questionnaires responded. Follow-up interviews were conducted with nearly 600 agencies, making the survey the most comprehensive of its kind to date.

Major findings of the study include the following information.

1. Millions of older Americans are going without the health care services they need. About 75 percent of agencies responding to the survey noted that a significant number of Americans in their communities were now going without necessary health care services.

2. The problem has been exacerbated by the enactment of DRG reimbursement for Medicare participating hospitals. First, because the evidence is clear that hospitals are discharging patients quicker and sicker. Ninety-two percent of the survey responses affirmed this conclusion. Second, some of these discharges are clearly inappropriate and have led to problems, injury and even death of individuals.

3. The DRG reimbursement system has saved billions of dollars for the Medicare program by shortening the average Medicare hospital stay by at least two days. Unfortunately, the Administration has shredded the home health care safety net, the premise upon which such shorter stays were endorsed.

4. Having saved billions of dollars in hospital reimbursement, Medicare has shortsightedly sought to reduce the level of expenditures for home health care as well. "In essence, the Administration has tried to trim the candle at both ends," the report concludes.

5. Patients are being told they are not sick enough to qualify for Medicare's home care benefit or that they are too sick. They are being told that they are excluded because they can get around too well or because some insurance clerk choses to overrule a physician's judgment that the care given through a home health agency was reasonable and necessary. "It is a Catch-22 situation," said Halamandaris. The clear intention is to discourage individuals from utilizing home care and to discourage agencies from caring for those who need the service.

6. Ironically, while the Department of Health and Human Services has ordered what the report describes as an incredible series of restrictions upon reimbursement by agencies, it has increased the number of people discharged into home care by 37 percent.

The following recommendations were made in the report.

1. Congress is urged to enact legislation requiring the Department of Health and Human Services (HHS) to comply with the Federal Administrative Procedure Act. There is strong evidence on the record that HHS has acted arbitrarily; that it has reduced the value of the Medicare entitlement; and that it has crossed the line between policy making (the prerogative of the Congress) and policy implementation.

2. Congress should establish within HHS an internal Office of Management and Budget. Such an office had existed, and was dismantled recently, leaving HHS under the control and domination of the Office of Management and Budget. HHS needs its own experts if the Secretary and other personnel are going to be able to carry out the duties for which they are responsible by statute.

3. Congress is asked to intervene to block the unintended double blows that will occur if the reductions in expenditures because of new administrative controls targeted at home health are combined with legislated general budget reduction measures.

4. Congress should consider exempting home health agencies (HHAs) from overall federal budget cuts and/or making reductions in a more equitable manner, one which takes into consideration the unfair effect of including cost-based reimbursements within the across-the-board reductions.

5. Congress should immediately enact provisions agreed upon in 1985 by the House Ways and Means Committee and the Senate Finance Committee which released agencies from the July 1, 1985 HHS regulations changing the formula for computing cost limits applicable to agencies.

The new rules barred agencies who were efficient from using savings in one area of service (e.g., nursing) to provide service in another area (e.g., physical therapy). This principle is called aggregation. The proposal would allow agencies to aggregate costs, at the same time preserving reductions in overall cost caps applicable to those agencies which had been mandated by HHS.

6. Congress should once again reject the Administration's proposal to add a 5% coinsurance to the home care benefit. Congress removed this impediment long ago in order to encourage utilization. Since much of the increased utilization of home care in the last 2 years has been a result of DRGs, coinsurance will do nothing to slow down utilization. Coinsurance is simply a tax on beneficiaries which would cost the government more to collect than it would save.

7. Congress should amend the provision in the Medicare law which limits those receiving home care to those needing "intermittent care." It is a cruel hoax to tell the elderly that they cannot be cared for because they need too much care, are too sick, and therefore, belong in a nursing home, knowing that Medicare pays for a very limited amount of such nursing home care. Only about 7,000 of the 1.3 million patients in nursing homes on any given day have their care paid for by Medicare, and their reimbursed stays tend to be very short--an average of 25-30 days. If the Congress insists on limiting the home care benefit, there are better ways to do so. NAHC has endorsed HR 2371, introduced by Congressman Henry Waxman, which would make it clear that the term "intermittent" would not block the care of individuals who otherwise qualify for daily visits up to 90 days.

8. Congress should enact legislation introduced by Congressman Ron Wyden which clarifies the right of providers to assist Medicare beneficiaries in appealing claims that have been denied by Medicare.

9. Congress should block HHS from denying Medicare home health benefits to individuals who supplement the care provided by Medicare. If families want to pay privately for additional care needed by relatives, they should be able to do so without causing a loss of Medicare's benefits.

10. Congress should enact proposals such as S. 1249 which passed the Senate in 1985, and S. 1793, expanding the scope of pediatric home care.

11. Congress should encourage family members to care for their relatives at home through appropriate tax deductions.

12. Congress should encourage all states to enact legislation similar to the Nursing Home Without Walls program which has been so successful in New York state.

13. Congress should enact comprehensive long-term care legislation such as that contained in HR 4287 introduced by Congressman Claude Pepper as part of any catastrophic health insurance plan which it considers.

Full copies of the report may be obtained by contacting The National Association for Home Care, 519 C Street, N.E., Washington, D.C. 20002, (202) 547-7424.

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